AFRICARE/GUINEA

MATERNAL AND CHILD HEALTH INITIATIVE (MCHI)

MIDTERM EVALUATION

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ACRONYMS AND FOREIGN TERMS

ADRA	Adventist Development and Relief Agency International
AGBEF	*Association Guinéenne pour le Bien Être Familial*
BASICS	Basic Support for Institutionalizing Child Survival
BHR/PVC	Bureau for Humanitarian Response/Private and Voluntary Cooperation
BSR	Office of Referral Support (in French)
CA	Community agent
CBD	Community-based distribution (distributor)
CDD	Control of diarrheal disease
COPE	Client-oriented, provider efficient services
DFSI	Dinguiraye Food Security Initiative
DPS	Prefectoral direction or director of health (in French)
DPT	Dyptheria, pertussis and tetanus vaccine
EPI	Expanded programme on immunization
FAMPOP	Family Planning Options Project
FY	Fiscal year
GTZ	German Technical Cooperation for Development
HIS	Health information system
IEC	Information, education and communication
IRS	Regional health inspector (in French)
KPC	Knowledge, practice and coverage
MCHI	Maternal and Child Health Initiative
MIS	Management information system
MOH	Ministry of Health
NGO	Nongovernmental organization
ORS/T	Oral rehydration solution/therapy
OSFAM	*Options pour la Santé Familiale*
PHC	Primary health care
PNLP	National Malaria Control Program (in French)
PRISM	*Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA*
PSI	Population Services International
SIAC	*System d'information à assise communautaire*
SO	Strategic Objective
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

A. INTRODUCTION

In November 1999, the United States Agency for International Development (USAID)/Guinea commissioned a midterm evaluation of the Maternal and Child Health Initiative (MCHI), a child survival project being implemented by Africare/Guinea. The four-year project began in October 1997. The purpose of the evaluation was to identify successes as well as problems, suggest areas which need further attention, and recommend useful actions to guide the staff through the second half of the project. (The scope of work is provided in annex A). The following is a summary of project achievements and recommendations.

B. PROJECT ACHIEVEMENTS

Addressing Malnutrition: The Hearth Model

Innovative Work: Capitalizing on its comparative advantage as a nongovernmental organization (NGO), MCHI/Africare has undertaken innovative work with the Hearth model, an approach that addresses malnutrition at the community level. Through this method, 117 (84 percent) of the 140 children present at the second post-Hearth weighing had been rehabilitated and mothers had begun to adopt feeding behaviors that should prevent malnutrition from recurring.

Advocacy: As a result of Africare's organization of a national seminar on the Hearth model, many other NGOs and ministries have become aware of the method. It has quickly become a potential model approach for malnutrition rehabilitation among other NGOs, including Plan/Guinea, Adventist Development and Relief Agency International (ADRA), and Action against Hunger.

National Application: More importantly, the Hearth model has the potential of becoming a means for the Ministry of Health (MOH) to reduce malnutrition rates nationally. In the fourth year of the project, Africare will work with the director of health (DPS) of Dabola to determine how the Hearth model can be adapted so the DPS can implement it as part of its own community-based strategy.

Increased Access

The MCHI project has increased access to primary health care (PHC) services by

- promoting collaborative efforts between community agents and MOH health workers so that more people take part in community-level health activities conducted by health center staff, such as vaccination days;
- training 48 community agents in nutrition, malaria control and prevention, diarrheal disease control, reproductive health, and IEC skills;
- implementing growth monitoring and Hearth activities to identify and rehabilitate malnourished children;
- constructing and renovating health posts;
- providing motorcycles to MOH agents;
- supporting and supervising community agents;
- developing a referral system;
- improving the emergency evacuation system from health posts to hospitals through the provision of radios to health posts; and,
- working with the United Nations Children's Fund (UNICEF) to develop a community-level emergency evacuation system.

Integration and Coordination

MCHI/Africare has developed an excellent working relationship with the DPS and other organizations operating in the area and effectively coordinates its work with these entities. For example, MCHI is:

- working with the UNICEF/Maternity without Risk Project to develop an emergency evacuation strategy to complement the project's provision of radios to health centers;
- working with *Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA* (PRISM) and 13 other organizations to standardize and share approaches to information, education and communication (IEC) in the region;
- working with PRISM, the *Association Guinéenne pour le Bien Être Familial* (AGBEF) and the National Malaria Control Program (PNLP) to standardize the training of health agents;
- providing information to PRISM's community-based strategy coordinator to standardize community-level data gathering and supervision instruments; and,

- serving as a resource to other NGOs interested in initiating the Hearth model.

Increased Quality

MCHI/Africare has increased the capacity of community agents to provide quality care in support of maternal and child health through training and support. It has developed monitoring instruments to track inputs and outcomes and is advocating for better support and recognition of community-level health activities.

C. RECOMMENDATIONS

1. Continue to implement the Hearth model. Help other NGOs learn about and implement it. Work with the DPS to improve the involvement of MOH health workers and community agents in its implementation. Develop a plan whereby health agents begin to take more and more responsibility for different aspects of Hearth implementation.

2. Work with the DPS to ensure that

    - health center staff members provide reports regarding all community-level activities at semiannual monitoring meetings,

    - health agents record vaccinations on the green *system d'information à assise communautaire* (SIAC) Road-to-Health card during village-level vaccination campaigns,

    - quality of service delivery is monitored among health agents,

    - performance standards for community agents are developed and monitored, and

    - an assessment of the quality of supervision of community agents by health workers is carried out, a plan is developed and implemented to improve supervision, and field agents' supervision responsibilities are gradually reduced.

3. Use very creative and multiple means to encourage health agents to take more interest and responsibility in monitoring community activities. These could include

    - sending a copy of the project's supervision form (of community agents) to the health agents,

    - discussing the content of the supervisory visit with the health agent, and

- inviting the health agents to a day of community agent training and involving the two in teambuilding activities.

4. Review the IEC strategy to

   - make sure that the messages are worded such that they incite action and are entirely correct,
   - ensure that community agents know the target audience for each message,
   - find ways to provide positive incentives for desired behavior changes,
   - ensure that each message has a visual means of communicating that is easy to use with groups or individuals, and
   - guide the community agents in selecting audiences for group presentations and home visits.

5. Develop a Logical Framework for the project in which

   - the indicators related to health center management capacity building reflect the actual role and responsibilities of the project and avoid duplication with other partners,
   - knowledge indicators are included for which baseline data are available,
   - the indicator for malnutrition is changed from chronic to acute (or simply malnutrition), and
   - other strategies (activities) to achieve project objectives are outlined (for example, exclusive breastfeeding support groups/community-based treatment of malaria).

6. Develop a detailed sustainability plan with indicators and means of verification that focuses on continuing the benefits of the project as well as some of the activities. This might include the formation and training of district development committees to support the community agents, establishing and testing other community agent (CA) support systems (such as resupplying of oral rehydration salts and contraceptives and regular supervision), and DPS management of the Hearth model.

I. PROJECT DESCRIPTION

A. BACKGROUND

In early 1997, the Guinean Ministry of Health (MOH) requested that Africare/Guinea expand the scope of the Dinguiraye Food Security Initiative (DFSI) to include a focus on maternal and child health. To that end, Africare, in collaboration with different partners (the regional health inspector [IRS], the director of health [DPS], the German Technical Cooperation for Development [GTZ], and *the Association Guinéenne pour le Bien Être Familial* [AGBEF]), developed and submitted a proposal to the United States Agency for International Development (USAID)/Guinea. In October 1997, Africare/Guinea was awarded a four-year grant in the amount of $2.3 million to fund the Maternal and Child Health Initiative (MCHI). The project is being implemented in Dabola and Dinguiraye prefectures in the Faranah region of Upper Guinea. The target populations of the project include 42,000 children under 5 years of age and 42,000 women of reproductive age.

The MCHI project seeks to improve maternal and child health by reducing maternal and child morbidity and mortality. This goal will be achieved by strengthening and expanding existing government health services and strengthening communities' capacity to manage their own health problems.

Indicators for measuring these objectives were developed and presented in the original proposal, but were then changed in the first continuation application to focus more on practices rather than knowledge. (These indicators are presented in annex D of this report.)

MCHI focuses on four interventions: nutrition, malaria prevention, control of diarrheal disease, and reproductive health. The project also supports the MOH's immunization efforts.

To achieve the project's objectives, MCHI has employed and trained a cadre of field agents who in turn help to train and support volunteer community agents (CAs). The CAs are village (called sector, in Guinea) residents selected by their community to provide a number of services in support of maternal and child health. These services include monthly growth monitoring and promotion, health education, identification and referral of sick children to the local health center, sale of oral rehydration solution (ORS) packets and a few types of contraceptives (not yet initiated as of the midterm evaluation), and assistance with the Hearth model.

The Hearth model is a strategy employed by the project to rehabilitate malnourished children and teach mothers feeding practices that will help avoid the recurrence of malnutrition in their children. (See chapter III for details regarding the Hearth model.)

The project also trains MOH health agents, assists with national vaccination day campaigns, has provided six motorcycles and two-way radios to health centers and health posts, is building and renovating health posts, and plans on supporting income-generating activities.

B. FIELD PROCEDURES

In November 1999, USAID/Guinea commissioned an evaluation of the MCHI, a project being implemented by Africare/Guinea in the Dabola and Dinguiraye prefectures of the country. The scope of work of the evaluation (see annex A) called for an assessment of the quality of programming, quality at the community level, quality of health worker and facility services, capacity building and sustainability, technical and administrative support, financial expenditures, and accomplishments and constraints. Other issues identified by USAID, Africare or the evaluation team were also investigated. The evaluation team consisted of six members and included representation from the project, the MOH and the Prefectoral Direction (DPS): Bonnie Kittle (consultant/team leader), Gouley Cisse (MCHI assistant coordinator), Tadiba Kourouma (MCHI assistant capacity building coordinator, newly hired), Kadiatou Keita (midwife from MOH, Conakry), Abdoulaye Diallo (MCHI assistant supervisor), and Etiene Wendeno (DPS head of health center).

The evaluation was conducted in four phases: document review and initial interviews, field work, data analysis and interpretation, and report writing. The field work consisted of indepth interviews with project staff, partners (MOH, DPS, the United Nations Children's Fund (UNICEF), *Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA* (PRISM), Population Services International (PSI), and GTZ), health agents, community agents, and beneficiaries (mothers) for which several instruments and discussion guides were developed (annex B). Approximately 125 interviews were conducted, as indicated in annex C. The evaluation team visited six health centers and four health posts as well as six districts.

Once the information was collected, the team spent 4 days analyzing and interpreting it, identifying findings, drawing conclusions, and developing recommendations. The most important of these were presented to the project staff for discussion. The team was then invited to the regional capital, Faranah, to present the results to all of the prefecture heads of health and hospital administrators (18), who were gathered for training. Upon return to Conakry, the team leader debriefed the USAID project officer before presenting the results to a group assembled by the Ministry of Health.

II. QUALITY OF PROGRAMMING

A. Relationship Between MCHI and Other Health-Related Activities

MCHI staff members have excellent working relations with the DPS (the local representative of the MOH) and the other partners of the DPS, including UNICEF, GTZ, and the USAID–funded PRISM project. The DPS considers Africare one of its most valued partners in the prefecture and collaboration between the two is very productive. The MCHI staff coordinates project activities directly with the DPS and consults with UNICEF, PRISM and GTZ to keep abreast of their initiatives and avoid duplication of effort. In order for the excellent level of coordination to continue in the absence of the DPS (who will be on sabbatical for most of the year 2000), a special structure needs to be put in place.

Project staff has participated in the UNICEF–funded annual workshop on nutrition activities, is a regular participant in the DPS' semiannual monitoring meetings, and serves as the secretary on the Regional Information, Education And Communication (IEC) Working Group. In addition, Africare is represented at meetings with USAID/Guinea's Strategic Objective (SO) 2 team when all of USAID's health and population grantees meet to share information about their activities. There are no other nongovernmental organizations (NGOs) implementing health activities in the prefecture.

When the project began, Africare inventoried prior endeavors and activities underway in the target zone. At that point, it was decided that rather than train a different cadre of community health agents the MCHI project would build upon the prior work of UNICEF's Integrated Project and the predecessor of the PRISM project, Family Planning Options Project (FAMPOP). Both of these projects had trained community health agents—one to combat malnutrition through growth promotion activities (*system d'information à assise communautaire* [SIAC] volunteers) and the other to serve as community-based distributors (CBDs) of contraceptives. Neither of these two types of agents was being optimally supported when the MCHI project began and the project encouraged community leaders to select these community volunteers for further training and support by the project. (The project also encouraged community members to select women for training, and now 30 percent of the community agents are female.) Africare used the SIAC volunteer training curriculum to train them in growth monitoring and promotion and will use the PRISM training curriculum to train them in community-based distribution of contraceptives.

Africare is also working with UNICEF's Maternity without Risk project to implement an emergency evacuation system for pregnant women and children with serious illnesses. Through the Maternity without Risk project, an Office of Referral Support (BSR) has been established. This is a committee formed at the village (sector) level, which manages an emergency evacuation fund. Many MCHI–trained community agents and traditional birth attendants (trained by UNICEF) are members of the BSR and serve as the link

between the community or individual in need and the BSR member who has the means to contact the health center and access the ambulance.

Africare is coordinating its work on malaria prevention with the National Malaria Control Program (PNLP). Because of the project's focus on malaria prevention and its reputation as a cooperative partner, the PNLP decided to make Dabola a pilot site for its mosquito net impregnation efforts. The project supported this by facilitating the participation of heads of four health centers in the mosquito net impregnation training that was implemented by the PNLP with support from UNICEF. In addition, the project is helping to train a second mosquito net impregnation unit in Dabola.

In addition to strengthening the community's ability to address its health problems, the project also seeks to strengthen health center staffs' ability to provide adequate care. To this end, the project has trained health center and health post staffs in each of the four technical components of the project. The project's field agents are regular visitors at the MOH health centers in Dabola. According to the MOH employees interviewed for this evaluation, MCHI staff (primarily field agents) visits the health centers several times a month. These visits serve to keep the health agents informed about project activities taking place in the sectors and to coordinate activities, such as sector vaccination days (*strategie avancé*). Project field agents may also follow up on sick patients referred to the health center for treatment and receive feedback regarding community members' attendance at prenatal consultations, etc. Because the number of MOH personnel is extremely limited in some health centers and visits to the field are infrequent, these visits by field agents help to maintain contact between the health worker and the community agent. Project staff also helps organize and implement vaccination campaigns, and the project has provided material support to each health center as well.

Africare's work in reproductive health in Dabola and Dinguiraye is helping the PRISM project meet its objectives. Furthermore, with Africare working in these two prefectures, PRISM can focus its time and resources on other parts of the region. PRISM can also learn from the work of MCHI, particularly the community activities which PRISM has yet to initiate. Members of the PRISM staff are working with MCHI to standardize IEC approaches and supervision instruments. MCHI staff has helped PRISM to train health agents in reproductive health norms and procedures and the Hearth approach may well prove to be a model for PRISM's child survival/nutrition component.

One area of possible duplication of effort exists. This is between the GTZ project, whose objectives include management capacity building of the IRS and DPS in the Faranah region, and the objective of the MCHI project, which is the same. Thus far, MCHI has avoided duplication by not providing management training at all. Given the comparative advantages of Africare (community development) and GTZ (institutional support), it is preferable to divide the resources accordingly and work to complement each other's efforts rather than to duplicate them.

B. LEVEL OF ACCESS OF MOTHERS AND CHILDREN TO HEALTH FACILITIES AND OTHER CHILD SURVIVAL SERVICES

The MCHI project has increased access of mothers to quality health services and facilities by

- training 48 community agents (many of whom are women), who provide child survival services at the community level,
- mobilizing community members to access MOH services being offered both at the health center and in the community,
- helping to improve the quality of service delivery by health agents by establishing a referral system for sick children, and
- facilitating emergency evacuation through the provision of radios to health posts and working with UNICEF's Integrated Project, as described previously.

Health agents interviewed for this evaluation all agreed that attendance at prenatal consultations had increased since the project began and that immunization coverage had increased due to wider participation in sector vaccination days. Training of community agents in growth monitoring and promotion means that each child (under age 3 is weighed once a month and their mothers receive some counseling and encouragement. This activity was found to be strongly supported by fathers as well. Many mothers interviewed mentioned that in addition to monthly growth monitoring, they had received other health services, such as group health education, vaccinations, Hearth, and hygiene/sanitation activities. The majority of mothers interviewed reported that health conditions in their community had improved in recent years.

C. PROJECT STAFF AND OTHER PERSONNEL RELATED TO THE PROJECT

As shown in table 1, workloads of the project staff appear to be evenly distributed with the exception of the supervisor. He is responsible not only for supervising the field agents, but also for the health and management information systems (HIS/MIS) and the IEC strategy. Furthermore, he plays a major role in training and implementing the Hearth model. The project has recognized this imbalance and plans to hire a person to be responsible for the HIS/MIS.

The project also plans on hiring additional field agents to take responsibility for the new cohort of communities into which the project will be expanding during the second half of the project. A capacity-building coordinator (to be hired) and her/his assistant will be responsible for establishing, training and supporting district development committees and overseeing income-generation activities.

The current organizational chart does not reflect these new hires or the project staff operating in the Dinguiraye prefecture and should be amended.

The evaluation team assessed the knowledge of field agents and found that while their knowledge in the area of nutrition is very strong (94 percent correct, on average), some field agents will need to review the technical aspects of control of diarrheal disease

(CDD), malaria and reproductive health. To their credit, however, the expectations of the project with regard to knowledge levels are quite high, for example, case management of a child with moderate dehydration.

Table 1: MCHI Project-Related Personnel

Title	No.	Organization	Role
Africare Headquarters Staff	4	Africare 5–15%	Project support, technical assistance, liaison
Country Representative	1	Africare–20%	Supervision, representation, program guidance
Administrator	1	Africare–40%	Financial and administrative support
Project Coordinator	1	Africare–100%	Project management, personnel supervision, representation at national level, program oversight, liaison with Africare Conakry/Headquarters, financial oversight
Assistant Coordinator	1	Africare–100%	Project management, supervision, coordination of activities, training curriculum development
Supervisor/Trainer	1	Africare–100%	Supervision of field agents, HIS data management, development of training curriculum for field agents, trainer, development and oversight of IEC strategy, implementation of Hearth model
Assistant Supervisor	1	Africare–100%	Supervision of field agents, trainer of CAs
Project Administrator	1	Africare–100%	Logistical coordination
Project Secretary	1	Africare–100%	Secretarial work
Field Agents/Dabola	9	Africare–100%	Training of community agents, supervision and monitoring of community agents, oversight of Hearth activities
Field Agents/ Dinguiraye	7	Africare–50%	Training of community agents, supervision and monitoring of community agents;
Supervisor, Capacity Building	0	Africare–100%	Will work to establish village development committees, oversee income-generating activities
Assistant Supervisor, Capacity Building	1	Africare–100%	Helping to form, train and support village development committees, oversee income-generating activities
HIS Coordinator	0	Africare–100%	Will be responsible for the HIS/MIS system
Community Agents	48	Community Volunteers	Carrying out of census, monthly growth monitoring, provision of health education, referrals to health center and follow up of referred cases, selling of ORS packets in sectors, carrying out of Hearth activities, monitoring of progress of Hearth participants
Regional Health Inspector	1	MOH	Oversight and coordination of health activities in the region, supervision of DPS, coordination with donors/project operating at the regional level
Director of Health, Prefect Level	1	MOH	Coordination of health activities at the prefect level, liaison with projects/donors
Health Agents	28	MOH	Provision of health services at health centers and vaccination in sectors, supervision of community agents

D. SUPPORT AND SUPERVISION

The project employs nine field agents in the Dabola prefecture who in turn supervise 48 community agents. The average number of community agents (CAs) per field agent is five, but in reality, the ratio of CAs to field agents ranges from 3:1 to 8:1. The ratio varies according to many factors: size of the area being covered both in terms of square miles and population; distance between health centers, districts and sectors; terrain; complexity of the community; and, experience with the project. Each field agent is supposed to supervise each community agent once a month. This usually occurs during the last two weeks of the month when growth-monitoring activities take place, since supervision activities include on-the-job training and data collection. To supervise the IEC aspects of the CA's job, however, a second visit would be necessary. It is not clear to what extent this is taking place since the field agents are quite involved with other activities (training preparation and implementation, and Hearth preparation) which require their presence outside the target communities. Furthermore, in order for capacity building to take place at an optimal pace, field workers should have more frequent contact (2–3 times a month) with each community agent.

The project has developed a supervision instrument to guide field agents' efforts. This tool (see example in annex E) collects information regarding the supplies and materials provided to the CA, the growth monitoring activity, home visits, referrals, number of family planning participants, and IEC activities. The *aide memoire* section at the end of the sheet serves to remind the field agent to provide feedback to the CA, to write the recommendations in the CA's notebook, and to provide feedback to the field agent's supervisor.

Although the instrument is effective in collecting project data, this tool is not well suited to assessing the community agent's **performance**. To be useful in supervision, therefore, the instrument needs to be modified to focus more on assessing the **quality of service delivery**.

The project supervisor and his assistant supervise the nine field agents. Although there is no specific schedule for supervision, both supervisors insist that they are frequently in the field overseeing field agents' work. Given the number of responsibilities delegated to the supervisor (see table 1), however, it is difficult to imagine him having time to supervise the field agents adequately, even with his assistant's help. A very general and open-ended supervision instrument is currently being revised to make it more specific and easy to use. The revised supervision instrument should focus on assessing and improving the field agent's performance.

Although the MCHI–employed field workers assume responsibility for supervising the community agents, in reality, this is the job of the MOH health agents, usually the person responsible for the vaccination program. Given the restricted number of health agents and their limited means of transportation, however, they are only expected to supervise the CAs once a quarter. According to a study conducted by MCHI, the majority of health agents are able to respect this schedule, although the actual content of the supervisory visit is not clear. Because regular supervision is a key to sustaining the work of the

community agents, the project needs to look for ways to assess and improve (if need be) the quality of supervision provided by health agents and gradually reduce the field agents' supervisory responsibilities.

The project coordinator's mechanism for supervising her senior technical staff is weekly meetings, during which the project's activities are discussed and determined. Although a schedule of project activities is developed for each month, senior staff members are not required to submit plans or reports of their own activities. As a result, there is no written record of their work.

E. CONCLUSIONS AND RECOMMENDATIONS REGARDING APPROPRIATENESS OF SUPPORT, SUPERVISION AND WORKLOAD

Conclusions

1. The project has significantly increased access to health services by training community agents and mobilizing mothers to make use of the services provided by health agents.

2. The project has strengthened the link between community agents and health agents.

3. The project effectively coordinates its activities with those of the DPS and other partners.

4. The MCHI enables the PRISM project to use its resources more effectively by taking responsibility for reproductive health and community activities in two prefectures.

5. A potential duplication of effort exists between the work of GTZ and MCHI in management capacity building among health center staff.

6. The absence of a standard of performance for community agents hinders effective supervision and support efforts.

7. The current monthly supervision approach focuses too much on quantity of work (and data collection) and not enough on quality of work.

8. Monthly supervisory visits of this sort are too frequent.

9. Support visits for the sole purpose of improving service delivery are not frequent enough.

10. Not enough is known about the quality of supervision provided by health agents to community agents.

11. MCHI field agents and senior technical staff are not being supervised systematically.

12. The chief supervisor is overburdened with work.

Recommendations

Relationships

1. Prior to his departure, the DPS should designate (in writing) one of his staff as the MCHI project point person. A schedule of regular meetings should then be established between this person and the project coordinator.

2. To avoid duplication of effort with GTZ, the MCHI project should officially drop the indicators related to health center management capacity building (see annex D).

Staff

3. As planned, the project coordinator should reduce the workload of the chief supervisor by hiring a person to take charge of the HIS/MIS.

Support and Supervision

4. In collaboration with DPS and other partners, senior project staff should develop a standard of performance for community agents.

5. The new HIS/MIS person should revise the supervision instruments (field workers or community agents and supervisors of field agents) so that they assess performance, not outcomes (e.g., quality of growth monitoring rather than the number of children weighed).

6. Field agents should share completed supervision forms with health agents, and systematically discuss results of supervision with the MOH supervisor.

7. Trainers should invite the health agents to participate in teambuilding activities with CAs as part of the training provided by the project.

8. Field agents should use the current supervision instrument (parts I and II) to collect data only.

9. MCHI should assess the **quality** of community agent supervision by health agents and develop and implement a strategy for improving the quality of this supervision. The involvement of project staff in CA supervision should

gradually decrease over the life of the project and should be shifted entirely to health agents.

10. The HIS/MIS person should reduce the frequency of **data collection** and **supervision** visits (of community agents) to about once every two months or once a quarter.

11. Senior project staff should reduce field agents' involvement in activities that take them away from their districts so that field agents are able to schedule and routinely conduct several support visits a month per CA to help improve their **performance**.

12. The MCHI supervisor and assistant should establish a regular schedule for supervising field agents (for example, once every two months).

13. The project coordinator should require senior technical staff members to develop their own calendar of activities and report on these regularly.

III. QUALITY AT THE COMMUNITY LEVEL

A. INFORMATION, EDUCATION AND COMMUNICATION (IEC) MESSAGES AND MEANS OF COMMUNICATING

The project has defined 21 key messages, which are divided into the following categories: breastfeeding, varied diet, hygiene, malaria, CDD, growth monitoring and vaccinations. (The key messages are presented in annex F.) While the content of the messages corresponds to 12 of the 16 behaviors considered essential to reducing infant and child morbidity and mortality,[1] there are no messages that promote the safe motherhood/family planning behaviors being used to measure project progress (prenatal consultations and contraception use).

In addition to missing some messages, the messages themselves are not well formulated and need to be reworded. More specifically,

- key messages should incite action—a few of the messages only provide information,
- the wording "ought to" is condescending—an imperative statement is more effective,
- the target audience of the message needs to be made clear in each message (i.e., Mothers! Only give your baby breast milk until he's 6 months old to avoid getting diarrhea),
- the diarrhea message about ORS is incorrect and needs to be modified, and
- the wording of messages needs to be specific. For example, the word "sufficient" in the varied diet message should be qualified, as should the message regarding feeding during and after diarrhea.

The project has included several messages about hygiene. While popular among project staff, community agents and beneficiaries, these messages are not related to the project's CDD objective (proper case management of diarrhea) and they have not proven to be particularly effective in preventing diarrhea within the context of a child survival project (with the exception of hand washing). In fact, an overemphasis of these messages has overshadowed some of the other messages, which have a better track record in preventing diarrhea (i.e., vaccinations and exclusive breastfeeding).

[1] *Emphasis Behaviors in Maternal and Child Health*, Technical Report, BASICS, 1997.

The community agent is the key communicator of the project's health and nutrition messages, which are communicated to target audiences at three different opportunities: during monthly growth monitoring, group health education sessions, and home visits. Prior to weighing babies once a month, most CAs will select a theme and present this to the assembled women. Counseling while the baby is being weighed seems to be limited to mothers of malnourished children who are advised regarding proper feeding practices and/or referred to the health center for follow up. Once or twice a month (on average), the community agent will assemble women on a non-growth monitoring day to hear another message. In addition, from time to time, a community agent will visit a mother at her home and deliver a message on an individual basis. Discussions with project staff revealed that key messages are not targeted to any particular subgroup of mothers, but rather are delivered generally to the entire community of mothers with the assumption that at some point in time, this message has been, is, or will be relevant to the mother. This approach is not the most effective. Studies have shown that mothers are most receptive to messages when they (or their child) actually have the problem being discussed or need the particular bit of information.

The project has provided each community agent with training and some visual aids to help communicate the key messages. From a review of the training curriculum, the interpersonal communication component appears to have been rather shallow. However, since the evaluation team observed no IEC sessions, definitive conclusions could not be drawn regarding the community agents' IEC skills. CAs have some visual aids but some messages (i.e., malaria prevention) lack an accompanying visual aid. A few of the images in the flip chart used by the CAs seem to be inappropriate and not to have been pre-tested (i.e., a picture of a purple baby).

A very positive activity of the project is the feedback session that the community agent holds every trimester with the communities he/she serves. During this presentation to the district leaders and community members, the CA reports on the activities he/she has carried out during the past quarter. The CA also reports on the number of cases referred, the number of children weighed, and the number malnourished. This activity reinforces the fact that the CA is not only accountable to the project, but more importantly, he/she is accountable to the community in which he/she works. The practice of providing feedback is very important and will pave the way for the formation of district development committees, whose task it will be to support the CA.

When the project initiated the Hearth model to rehabilitate malnourished babies, it created two other mechanisms for influencing child feeding practices: the *maman lumiere*, or the mother of light, and modeled behavior for appropriate feeding. The *maman lumiere* is a model mother because, in the absence of extraordinary means, she is able to maintain her baby in good health. This woman is selected by the project following a home visit that includes a questionnaire to determine positive feeding and health practices, a 24–hour diet recall, and observation.

The *maman lumiere* serves as a practical model for participants in Hearth activities. She participates in a 4–day training session to learn the key messages of the project and how

to communicate these to other mothers. When mothers come to the Hearth training each morning for 12 days, the *maman lumiere*, along with the CA and project staff, communicate the key messages to the Hearth participants. A study of Africare's implementation of the Hearth model suggests that the *maman lumiere* often becomes a resource mother in her community who reinforces the key messages (particularly the ones on hygiene and feeding) even after the Hearth training is finished. Further study of this unintended effect would be useful.

Thus far, it appears that the most effective means of changing mothers' behaviors has been through the Hearth activities. Not only do the participating mothers hear the key messages repeatedly and from various sources during a significantly long period of time (12 consecutive days), but they practice many of the messages as well—food hygiene, hand washing, varied diet, portion size, persistence in feeding, breastfeeding, etc. The practices are reinforced by community leaders, husbands, health agents, and everyone associated with the project, and are rewarded (and therefore reinforced) in most cases by visible positive changes in the child's behavior. Even before weight gain is assessed, the majority of participants in the Hearth training report that their once lethargic baby became lively and happy as a result of the feeding.

B. PROJECT ASSESSMENT OF UNDERSTANDING OF MESSAGES AND USE OF INFORMATION

The project does not systematically assess understanding of key messages or levels of knowledge and practices. The closest the project comes to following up in this regard are periodic visits to Hearth participants' homes to see if the mothers are continuing to follow the feeding practices promoted during the Hearth training. However, these efforts pertain to a very small percentage of the target population, are not systematic, and do not produce data that are used to make future decisions. The project collects data on the number of ORS packets sold by the community agent, but thus far, these data have not been used to track changes in diarrheal disease case management. Health centers collect data on the number of prenatal consultations provided and children vaccinated, and project staff participate in semiannual monitoring activities during which these data are compared to the previous reporting period. The project does not take particular note of this information, however, in part because the MOH uses a reporting formula (effective coverage, adequate coverage) that does not meet the needs of the project.

The project may be less inclined to track knowledge because at the time of the continuing application (July 1998), all but one of the knowledge indicators were changed to practice indicators (see annex D). Changes in knowledge levels are important indicators (and usually precede changes in practice), especially when related to practices that are particularly difficult to affect, such as infant feeding. The project should consider reinserting the knowledge indicators for which they have gathered baseline data.

The practice that the project does track systematically is growth monitoring. Each month, the field agents check the number of children under age 3 that were weighed, the number malnourished, and to what degree. These results do not correspond to the project's child nutrition indicator, however, because the indicator relates to **chronic** malnutrition (stunting), which is measured by height for age, while the project uses

weight for age, which measures **acute** malnutrition. In addition, the way the census was taken (registering women/children who came to a central registration spot) does not allow the project to know with certainty the **percentage** of the population's children under age 3 who are registered and being weighed and therefore, the **percentage** that is malnourished.

C. ASSESSMENT OF UNDERSTANDING OF MESSAGES AMONG TARGET AUDIENCE

The evaluation team interviewed a total of 68 mothers of children less than 2 years of age. Among other things, the team sought to determine the extent to which mothers understood the primary messages of the project (see annex F). As table 2 shows, the vast majority of mothers demonstrated an understanding of the breastfeeding messages. The weakest point in the varied diet section concerns the number of meals a baby requires. Three quarters of the mothers could name two ways to prevent diarrhea and at least one appropriate diarrhea case management technique. Half of the mothers interviewed knew what causes malaria and could cite one way to avoid getting the disease (compared with only 37 percent among health workers). The message about seeking help for a child with a fever was familiar to the majority of mothers. Mothers' knowledge regarding the vaccination schedules for pregnant women are particularly weak.

These results reflect the fact that the project has focused much of its attention thus far on nutrition, and that the nutrition messages have been reinforced by the Hearth training. The CAs received training in nutrition in October 1998, a year before the evaluation, and training in malaria in July 1999, only three months prior to the evaluation. With time, mothers are likely to absorb the other messages with equal efficiency.

Table 2: Knowledge among Mothers Living in the Project Area (n = 68)

Component/Question	Correct Responses
Breastfeeding	
1. What should a mother first give to her newborn after his birth?	58 (85%)
2. Do you know about colostrum? (yes)	64 (94%)
3. Why is it important?	56 (83%)
Varied Diet	
4. When should a mother start to feed her child other foods in addition to breast milk?	50 (73%)
5. As of 6 months of age, what should a baby eat?	58 (85%)
6. As of 6 months of age, how many meals does a baby need to have each day?	41 (61%)
Diarrhea	

7. What should a mother do to avoid getting diarrhea?	51 (75%)
8. What should you do for a child with diarrhea?	50 (73%)
Malaria	
9. What causes malaria?	35 (51%)
10. How can you protect yourself against malaria?	36 (52%)
11. What should you do if your child gets a fever?	52 (77%
Vaccinations	
12. Why should you vaccinate your child?	67 (98%)
13. At what age should a child be completely vaccinated?	35 (51%)
14. How many times does a pregnant women need to be vaccinated?	26 (39%)

D. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. The project has promoted the sense of ownership by institutionalizing feedback sessions to the community. This activity has also set the stage for the establishment of community development committees.

2. The content of the key messages corresponds to the key behaviors considered essential to reducing infant and child morbidity and mortality.

3. The list of key messages is incomplete. Messages regarding the need for prenatal consultations and contraceptives are missing.

4. The Hearth model is probably the project's most effective behavior change strategy because it includes most, if not all, of the elements that most effectively promote behavior change.

5. The non-targeting of IEC messages has compromised the effectiveness of the IEC strategy.

6. The project's current means of influencing mothers' behaviors are quite limited (CAs communicating messages, providing products and Hearth activities), and, on its own, may not result in significant changes in behavior.

7. Some *maman lumieres* have become positive change agents in their communities who also reinforce the key messages of the project.

8. The project does not systematically assess mothers' knowledge levels or track other intermediary indicators related to practices (sales of ORS).

9. The project uses its growth monitoring activities, primarily to identify malnourished children for inclusion in Hearth activities. It is not being used to its fullest potential, such as targeting health education messages.

Recommendations

1. Develop key messages that specifically promote prenatal consultations and the use of contraceptives.

2. Review the list of key messages and reword these to address the specific issues identified previously. Identify the primary target audience for each message and use the messages to communicate the ideas.

3. Help CAs target their IEC efforts by establishing general criteria for group education sessions and home visits. Focus less on hygiene and more on case management and other means of preventing diarrhea (i.e., exclusive breastfeeding, measles vaccination). Use the growth monitoring activity as a means of identifying the messages mothers need to hear.

4. When district development committees are formed, provide technical training to them so they can reinforce the key messages of the project.

5. Conduct research on the impact of the Hearth training (both of the *maman lumiere* and of the participants) on non–Hearth participants.

6. Consider developing other strategies for promoting desired behavior change. For example, to encourage and support immediate and exclusive breastfeeding, the project could pilot test the formation of breastfeeding support groups, as described by Wellstart.

7. Revise the current list of indicators to include knowledge indicators for which there are baseline data.

8. Change the indicator related to malnutrition from chronic malnutrition to acute malnutrition (or simply malnutrition).

9. As part of a comprehensive IEC strategy, identify ways to provide positive reinforcement to mothers/communities that adopt desired behaviors or practices, for example, a certain percentage of children under 3 years with normal weight for the quarter or a certain percentage of new mothers who exclusively breastfeed their infants.

IV. QUALITY OF HEALTH WORKER AND FACILITY SERVICES

A. FACILITY, HEALTH WORKER (MOH) AND COMMUNITY AGENT KNOWLEDGE, SKILLS AND PRACTICES ASSESSMENT

The project trains and supports two types of health workers: the community agent, a community volunteer, who provides some basic preventive services and health education; and, the health agent (also referred to as a health worker), an MOH employee based in a health center or health post, who provides a variety of health care services.

To improve access and quality of service delivery, the project trains both health agents and community agents in the four technical areas of the project. The cascade approach is used, whereby field agents and MOH health workers are initially trained. Following their training, the community agents are trained. Unfortunately, the ministry's health workers, once trained, do not help train the community agents. Rather, the project's field agents train them, with MOH personnel being involved only sporadically and for certain parts of a course. Apparently, the health workers are so overworked that they do not have time to participate in the CA training.

The project has designed and conducted three courses for MOH agents and six courses for community agents, as shown in table 8 in chapter V. Pre- and posttests are systematically administered and serve to assess the participants' levels of knowledge following the training event. In all cases, the posttest scores were higher than pretest scores. To assess the trainees' retained knowledge in the subjects in which training was received, the evaluation team administered its own questionnaire, the results of which are shown in tables 3 and 4.

Table 3 indicates that many of the health agents did not retain the information provided during the training. Out of 15 questions, only 7 were answered correctly by more than half of the health agents. This poor showing probably reflects the lack of reinforcement (or use) of the information following the training, rather than on the quality of the training, since posttest scores were reasonably high. Furthermore, while project field workers continue to reinforce the lessons of the training among the community agents, this is not done (nor is it an appropriate role for field agents) among the health workers.

Table 3: MOH Health Agents' Knowledge Levels

Component/Question	Number of Correct Responses

Component/Question	Number of Correct Responses
Nutrition (n = 6)	
1. What is the advantage of vitamin A?	4
2. What advice would you give to a pregnant woman about feeding her newborn?	6
3. What actions should a mother take to assure the health of her baby?	4
4. Why should a baby begin to eat at age 6 months?	3
Diarrhea (n = 6)	
1. What are the signs of (moderate) dehydration in a child?	2
2. How do you treat a child with moderate dehydration?	0
3. What advice should a community worker give to a mother about taking care of a child with diarrhea?	3
Malaria (n = 8)	
1. What are the signs of serious malaria?	2
2. What is the treatment for serious malaria?	8
3. What can you do to prevent getting malaria?	3
4. Why is it particularly serious when a pregnant woman gets malaria?	6
Reproductive Health/Family Planning (n = 4)	
1. What are the signs of a sexually transmitted disease?	2
2. What advice should you give to a patient you think has HIV/AIDS?	0
3. What advice would you give a woman if she forgot to take her pill the night before?	4
4. Having stopped Depo-Provera, how long afterward does fertility return?	3

Table 4: Community Agents' Knowledge Levels (n=16)

Component/Question	Number of Correct Responses
Nutrition	
1. Why do you weigh babies?	15
2. How can you distinguish between a well nourished and a malnourished child?	16
3. What is the importance of colostrum for a baby?	15
4. At what age should a baby receive foods in addition to breast milk?	15
5. What steps should be followed to ensure proper feeding of a child?	13
Diarrhea	
1. What measures can be taken to avoid getting diarrhea?	9
2. What should a mother do to care for a child with diarrhea?	10
Malaria	
1. What are the signs of malaria that require an urgent referral?	10
2. What should a CA do for a child with malaria?	15
3. Malaria is more dangerous among which groups?	13
4. What measures can you take to protect yourself against malaria?	13
Interpersonal Communication	
1. What are the qualities of a good message?	11
2. What are the qualities of a good communicator?	12
3. What are some obstacles to good communication?	5

The community agents revealed higher levels of retained understanding of the project messages (content of the training) than did the health agents, presumably because they use the information more often and are supported more regularly. Their understanding of

the key nutrition messages is greater than the other two technical components and there is particular need to reinforce the diarrheal disease messages.

During each training course, information about interpersonal communication is reviewed. **Knowledge** about interpersonal communication and the **ability** to communicate effectively are two very different things, however; when it comes to behavior change communication, the trainers would do well to focus more on performance than on knowledge and to devise ways to assess CAs' abilities to organize and execute group health education sessions as well as one-on-one events.

B. QUALITY OF SERVICE TOOLS USED BY THE PROJECT

As table 5 shows, the project has developed a vast array of instruments and tools to monitor project inputs and outcomes and to assess quality of service. This attention to tracking mechanisms may be a result of the project being considered performance-based by USAID/Guinea. This means that each year's funding is based on the performance of the project, which is different from other funding mechanisms. According to the USAID/Guinea project officer, MCHI's performance each year is determined by the extent to which the project's schedule of activities has been implemented and certain process indicators achieved for the year.

A review of the instruments cited below revealed the following:

- In a few instances, data (for example, numbers of malnourished children) are being gathered by several different sources/instruments;
- The tool used to supervise community agents focuses more on outcomes (numbers of IEC sessions, number of children weighed) than on performance (quality of IEC sessions, quality of growth monitoring and counseling);
- The original tool used to supervise field agents (which is being revised) is too open ended;
- There appears to be no standard protocol for classifying or using the referral forms once they reach the health center;
- Some community agents are not recording deaths or referrals in their registers;
- Field agents' advice to community agents about how to set up and complete the register differs resulting in variances in data collection instruments;
- Health agents are not recording vaccinations on the green SIAC Road-to-Health cards; and,
- None of the tools/instruments relate to the supervision of technical (senior staff).

Table 5: Quality Assurance Instruments Used by MCHI

Name of Instrument	Used by	Purpose
Growth Monitoring Register	Community Agents	A register of names of children under 3 years of age; record of family information and monthly weight; also contains information about Hearth participants and cases referred to the health center
Monthly Report Form	Community Agents	Completed by CA and used by field agents and MOH health agents to monitor the work of CAs
24–hour Recall Form	Field Agents	Collect information regarding child feeding (and other information) habits among positive deviant mothers in preparation for the Hearth training
Hearth Guide	Field Agents and Community Agents	Describes the steps necessary to carry out the Africare/Guinea Hearth strategy
Growth Monitoring Census	Community Agents	Form used to register children under 3 years of age who will participate in growth monitoring activities
Schedule of Activities for the Health Center	Community Agents and Health Agents	Completed by the CA, used to help MOH health agents know and follow what activities the CAs are carrying out each week so the health center can coordinate its activities with those of the CA
Evaluation Form—Nutrition	Trainees	Used to evaluated a training event
Referral Register	Community Agent	Forms completed by the CAs and given to children who need to receive medical attention at the health center; forms kept by health center staff
Community Chart (*tableau communautaire*)	Community Agent	Large Road-to-Health chart that is used by CA to summarize the monthly weighing so that mothers and other community members can see the nutritional status of the children weighed that day
Road-to-Health Form	Community Agents	Used to track weight gain of children; also serves as the vaccination card
Organizational Chart of the Project	All Staff	Used to indicate the hierarchy among project staff and who supervises whom
Community Agent Supervision Form	Field Agents	Used to supervise CAs each month
Supervision Schedule	Supervisor and Assistant Supervisor	In the process of being revised; used to guide and track supervision of field agents
Motorcycle Use Form	Field Agents	Used to track use of motorcycles
Job Descriptions	All Staff	Written by each staff member to guide them in their work; determine position in hierarchy and understand supervision responsibilities
Activity Planning Chart	Field Agents	Planning form used by supervisors to monitor the monthly activities of field agents; posted in the health centers so health workers can know when certain activities are planned

Name of Instrument	Used by	Purpose
Market Survey	Field Agents and Technical Staff	Inventory of what is available in the market and the prices; used to develop recipes for the Hearth training
Hearth Activity Form	Field Agents	Used to track the daily activities of the Hearth model (presence of children, weight, etc.)
Pre- and Posttests	Trainers	Used to assess levels of knowledge achieved by trainees following a training event
ORS Space Assessment	Field Agents	One-time tool, used to assess the space put aside to treat dehydrated kids

C. MATERIALS/SUPPLIES FOR EACH TYPE OF HEALTH WORKER/FACILITY

Tables 6 and 7 list the supplies, materials and equipment provided to the community agents and health centers.

Table 6: Supplies, Materials and Equipment Provided to Community Agents

Communities/Community Agents
Bicycle
Boots
Raincoat
Backpack
Community register (large ledger)
Several notebooks and ruler, pens, pencils, etc.
Monthly report forms
Referral forms (with copies)
Scale with halter
Supply of Road-to-Health forms
Community growth board
Posters on vitamin A, breastfeeding, and ORS
Brochures on CDD
ORS packets (150–250 packets)
UNICEF–produced flip chart (*boite à image*), visual aids on diarrhea prevention and case management

Community agents provided the items listed above to communities for use. Bicycles are required for getting around to each of the communities covered by the CA because, in Guinea, populations are not grouped in villages as much as they are dispersed over a sometimes large geographic area. That is also why a backpack, raincoat and boots were considered essential. Each month the field agents take stock of the equipment, supplies and materials as part of the supervisory visit and replenish supplies as necessary.

The CA has all of the reporting forms and instruments he/she needs but lacks some visual aids. Given the need to cover several communities and not working from a central point, posters are not the most effective visual aid. Rather, community agents need more portable aids, such as the *boite à image*. Similarly, the community growth board is not easily portable. As mentioned previously, some key messages are not accompanied by visual aids.

Table 7: Supplies, Materials and Equipment Provided to Health Centers, Health Posts and Health Workers

Health Facilities/Health Agents
Six Motorcycles
Four Two-way Radios
Posters: ▪ Breastfeeding ▪ Vitamin A ▪ Conceptual Framework of Malnutrition ▪ CDD Case Management
Documents: ▪ Hearth Model ▪ Steps in the Hearth Model ▪ Training Module on Feeding and Nutrition (Food and Agriculture Organization [FAO], UNICEF) ▪ CDD Training Module ▪ Malaria Control Training Module ▪ Contraceptive Technology (AGBEF) ▪ Management and Quality of Services (AGBEF) ▪ IEC Training Module ▪ CA Service Delivery Training Guide (AGBEF) ▪ Designing by Dialogue (USAID, SARA)

The motorcycles were provided to those health centers where transportation was a serious constraint. They enable the expanded program on immunization (EPI) health agent to conduct regular vaccination campaigns in the communities and to supervise community agents more regularly. The posters were provided to health centers and were visible during the evaluation site visits. The health workers who participated in the training events organized by the project received the documents noted above. The provision of the training modules is noteworthy in that the health agents would then be able (presumably) to provide the same training to other health agents, thereby increasing the number of trained MOH personnel.

According to the project proposal, the DPS was expected to receive mopeds (*mobylettes)* as well. Since their transportation needs had already been met, the project provided a photocopier, a much needed and appreciated piece of equipment.

D. THE HEALTH INFORMATION SYSTEM

The project does not use the MOH health information system, in part because it does not analyze information in a way that would be useful to the project. Furthermore, since the MOH does not have nutrition or community activity indicators, it does not collect this information. This is a major constraint to the project, as the MOH's information system does not provide an incentive to health agents to support nutrition or community activities. Given the performance-based nature of the project, MCHI regularly collects information regarding outcomes and activity completion and this is reported to USAID/Guinea each year in its annual report. As mentioned above, the only impact

indicator that the project reports on consistently is malnutrition; the rest will be assessed during the final knowledge, practice and coverage (KPC) survey.

E. CONCLUSIONS REGARDING EFFECTIVENESS OF TRAINING, SUPPORT, MONITORING, AND SUPERVISION OF SERVICE DELIVERY

Conclusions

1. The project has developed a very comprehensive management and health information system. Instruments for the most part are simple and easy to use.

2. The project's information system has helped bridge the gap between health center staff and community agents. Most health agents coordinate their activities with those of the CAs by making use of the monthly work plan.

3. There is some duplicative collection of information.

4. The supervision tools (CA and field workers) are more effective in collecting outcomes than in assessing or promoting improved quality of performance.

5. Referral forms are not classified or used in a standard fashion.

6. The MOH provides little incentive to support nutrition or community-level activities.

7. The project will have a difficult time assessing vaccination coverage because the health agents are not recording vaccinations on the Road-to-Health card.

8. The project's provision of equipment and supplies to community agents has been appropriate, with the exception of the quantity and type of visual aids.

9. The project's tracking of outcomes is appropriate for its performance-based funding mechanism.

Recommendations

1. When the new information systems position is filled, senior staff should take the opportunity to thoroughly review the MIS/HIS, putting particular emphasis on value and use of information gathered, and scale back data gathering, wherever possible.

2. The new HIS person should revise the CA supervision form to focus more attention on quality of service delivery. This might require the development of separate instruments (such as checklists) to periodically assess implementation of specific activities (growth monitoring, IEC sessions, home visits, etc.).

3. The new HIS person should revise field agents' monthly reports to focus on CAs' performance rather than on growth monitoring statistics.

4. Provide crayons to CAs so they can color the Road-to-Health charts, which will make it easier for mothers to understand the card.

5. The project should not create more visual aids, but rather it should research (through the Africare network in West Africa, for example) for which health messages visual aids have already been developed and either adopt or adapt these to the Guinean culture.

6. In consultation with the head of the health center, develop a protocol for filing and use of the reference forms.

7. The project should request the DPS to require heads of subprefecture health centers working in the project area to report on community activities, either in a separate report (for which the project could help develop a format) and/or orally at semiannual CTPS meetings.

8. Request the DPS to require health agents to record vaccinations on the Road-to-Health card. Explain to health agents why this is important and support compliance during community-level vaccination campaigns.

9. Senior staff members should prepare and submit to the coordinator brief reports of their work (how they spent their time) every two months. These should focus on their individual tasks, such as the number of field workers supervised.

10. All staff, including senior staff, should prepare monthly work plans that identify such things as field trips and their purpose and CA contacts and the content.

V. CAPACITY BUILDING AND SUSTAINABILITY

A. PROJECT PLANS AND PROGRESS TOWARD INCREASING PARTNER CAPACITY

The project did not begin with a detailed capacity building strategy that identified desired performance or training needs. Rather, building on the projects that had preceded it (UNICEF's Integrated Project and Family Planning Options Project [FAMPOP]); MCHI set out to train community agents in each of the four technical areas of the project, as well as growth monitoring. Following the cascade approach to training, the health agents and field workers were trained first and then the community agents were trained. None of the agents' training needs were assessed in advance, however, or based on an analysis of desired performance. The project planned to conduct a training needs assessment of the health agents, but was discouraged from doing so by USAID, as another USAID grantee, PRISM (with Population Council), was due to conduct a nationwide assessment, which was thought to produce results useful to the project. As a result, the health agent training was based more on the project's needs than on the health agents' particular needs.

During the first half of the project, Africare focused primarily on developing capacity at the community level, more specifically on the community agent. While MCHI provided training to both health agents and community agents, as shown in table 8, the field agents were able to follow up on the training with regular field visits which helped the CAs put into practice what they had learned. The absence of this follow-up support for health agents resulted in many of them forgetting what they had learned, as shown in table 3. In fairness to the project, however, the most appropriate means of following up on the training is not particularly evident. The field agents, most of whom are not official health care providers, are not suited for this task. The MCHI doctors on staff, while capable, do not have the time or authority necessary to provide this kind of support to health agents.

MOH capacity building was one of the original objectives of the project. The project proposal included as one of its objectives, "to strengthen and expand existing government health services," and proposed to measure this by the following indicators:

- 90 percent of health personnel will have participated in MCHI–sponsored training courses,
- 80 percent of health personnel will appropriately treat and/or refer childhood illnesses (diarrhea, malaria, and malnutrition),
- Six new health posts will be constructed,
- 80 percent of health facilities will have functioning cost recovery systems, and
- 90 percent of health facilities will be submitting accurate monthly reports on time.

Table 8: Training

TOPIC	DATE	LENGTH (in days)	TRAINEES	No.
Training of Trainers	7/20–24/98	5	Africare Staff: MCHI, DFSI	9*
Nutrition	7/28–1/98	5	Field Agents	9
			Assistant Supervisor	1
			MOH Agents	6
Malaria/Nutrition Retraining	7/27–30/99	4	Community Agents: Dabola: 1st group CA	16
			Dinguiraye	1
Nutrition/Communication	6/7–12/99	6	Community Agents: Dabola: 2nd group	35
Diarrheal Disease Case Management	6/14–16/99	3	Community Agents: Dabola: 2nd group	35
Malaria Control and Nutrition Retraining	10/4–7/99	4	CA: Dabola	35
			CA: Dinguiraye	10
Diarrheal Disease Control	1/12–16/99	5	Field Agents	9
			Assistant Supervisor	1
			MOH Agents: Dabola	9
			MOH Agents: Dinguiraye	2
Malaria Control	7/5–9/99	5	MOH Agents	9
			Field Agents: Dabola	9
			Field Agents: Dinguiraye	8
			Assistant Supervisor	1
Reproductive Health	9/13–16/99	4	Field Agents: Dabola	9
			Field Agents: Dinguiraye	8
			Assistant Supervisors	2
Reproductive Health	9/13–22/99	8**	MOH Agents	4
11 Courses		55		

* At least 9 individuals were trained.
**4 days in common with field agent reproductive health training

The continuation application makes no mention of these indicators, but cites the following as the project's newly adopted indicators for MOH strengthening and expanding:

- number of new health posts constructed,
- number of health posts renovated, and
- number of health centers with adequately functioning cold chain equipment (subsequently dropped following baseline data survey).

Since there was no written communication between USAID/Guinea and Africare about these changes, it is not clear whether the changes were officially recognized, as they would have been as part of a Detailed Implementation Plan under the Bureau for Humanitarian Response/Private and Voluntary Cooperation (BHR/PVC). Discussions with the USAID project officer seem to indicate that the continuation application and any changes it contains becomes the base document and therefore, it appears that MCHI is

not required to use the indicators presented in the proposal to measure MOH strengthening efforts.

Given this and the fact that the present indicators relate to expansion rather than strengthening, the project should consider rephrasing the objective to reflect this (eliminate the word strengthen and leave expand). However, the project is supporting and strengthening the DPS' capacity in other ways (strengthening the link between health agent and community activities; increasing knowledge about malaria, CDD, nutrition, etc.) and it may want to revise its indicators to more accurately reflect these efforts.

B. PROJECT SUSTAINABILITY – PLANS AND PROGRESS

The project's sustainability plan outlined in the proposal envisioned project activities and benefits being sustained through two means: community support of community agents' activities and MOH support of community activities. The first approach relies on the formation, training and support of community- and district-level development committees that will "lead the community mobilizing, organizing and coordinating development activities," some of which presumably would include health activities. The proposal also suggests that at least some of these committees or the health center would find the means and motivation to pay the community agent a small stipend. Income-generating activities are also mentioned in the sustainability section of the proposal, but the link between these activities and sustained primary health care (PHC) activities is not clear. And, finally, it is assumed that the profit from the sale of certain commodities, ORS packets and contraceptives, would "serve as a sustainable financial motivation to continuing community agents' efforts."

Thus far, the project has not established any development committees. The idea was considered but it was decided to establish the community agents and investigate the presence of indigenous groupings before forming the committees. Although most projects do form the committees first, MCHI seems not to have suffered from having done it the other way. For example, despite the fact that communities do not provide direct support to their CA, the community agents interviewed for the evaluation seemed very satisfied with their work and well supported by the project. This leads one to speculate that community members may be more inclined to support the CA by serving on and supporting a community development committee, now that they have experienced the benefits of the community agent's work. Having completed the research, the project plans on establishing committees during the second half of the project and has designated two staff positions to take responsibility for this activity.

The project has taken steps to initiate income-generating activities. Rather than implement this component themselves, however, MCHI decided to identify a local NGO with income-generating experience and subcontract the implementation of this component to them. To this end, a study of local NGOs was conducted recently, the results of which are being reviewed. While this is the most intelligent way of handling this component, the link between the main objectives of this project and this component are vague at best. Furthermore, with the addition of the time and energy intensive Hearth

activities and the establishment of community development committees, it is doubtful that the project will have the time necessary to oversee the implementation of this component. Income-generating activities require specific expertise and a significant amount of time. It is doubtful that the project will benefit from any input into this component, and it is possible that energy expended (even under a subcontract) may detract from other activities that are directly related to achieving the objectives.

With regard to profits from the sale of commodities, it is too early to know how much income this will generate. The project had just provided each CA with a supply of ORS packets (which will be resupplied through the MOH) and the sale of contraceptives had not yet begun. If experience from other projects holds true for MCHI, however, it is unlikely that these sales will generate enough income to form the primary motivation of the community agents.

The project proposal cites the MOH's commitment to primary health care and continued support of the community agents as positive indicators of sustainability. While this commitment may exist in theory, it is visible to only a small degree in practice. To truly demonstrate this commitment, the MOH will need to develop national nutrition indicators and acknowledge the importance of community-level activities by holding health agents accountable for these. While waiting for a national commitment, in Dabola, the DPS has already taken steps to reinforce the staff of health centers by initiating the recruitment of a cadre of health agents who (he says) will be responsible for community-level activities. If the schedule holds, these agents should be in place within the next year. The deployment of these health agents is essential to activity sustainability, since regular supervision and support have been found to be the key to sustained quality performance.[2] The placement of additional health agents in late 2000 allows the project to concentrate on training the new agents to supervise and support the community agents during the last year of the project.

Thus far, the project has been operating without a detailed sustainability plan. In fact, the plan most often referred to by project staff and the DPS is the continuation of project activities by the DPS and his staff. This notion, however, is not accompanied by specific strategies and detailed plans. A sustainability plan needs to be developed and executed deliberately if activities and benefits are to be continued following the project.

C. CONCLUSIONS AND RECOMMENDATIONS RELATED TO CAPACITY BUILDING AND SUSTAINABILITY

Conclusions

1. Training has been provided based more on the objectives of the project than on an analysis of the training needs of the community agents and health agents relative to a universal standard of performance.

[2] *Sustaining Health Worker Performance in Burkina Faso*, Technical Report, BASICS 1997, and *Sustainability of a Community-Based Mother-to-Mother Support Project in the Peri-Urban Areas of Guatemala City*, Technical Report, BASICS and La Leche League, 1997.

2. The performance assessment conducted by PRISM is only marginally useful to the project.

3. The project staff's (field agents and technical staff) ability to influence changes in (MOH) health agent performance is very limited.

4. MCHI is not being held accountable by USAID for three of the original indicators related to MOH strengthening. At present, the project has no appropriate indicators for measuring its MOH strengthening efforts.

5. Progress toward achieving sustainability cannot be measured or assured in the absence of a detailed sustainability plan. Although the sustainability plan outlined in the proposal calls for the DPS to take over responsibility for the activities initiated by the project, without an analysis of capacity-building needs and a plan to increase capacity, there is no assurance that health workers will have the skills and knowledge needed to take over at the project's end.

6. Until the MOH demonstrates a commitment to nutrition and community activities by setting measurable indicators for these and additional health agents are recruited, hired and deployed, the ability of the MOH to become more effectively involved in supporting community activities and eventually assuming responsibility for these, will be seriously impaired.

7. The fourth year of the project will focus on implementing the exit strategy (i.e., training MOH staff to support community activities).

8. Although efforts to transfer responsibility of the current activities have a good chance of succeeding if additional health agents are deployed, the need for additional support from Africare will still be likely to expand activities to include maternal nutrition and additional reproductive health activities.

9. The delay in forming development committees has prevented the project thus far from securing tangible support for community agents from the communities.

Recommendations

1. Use the standards of performance for community agents to determine further training needs.

2. In collaboration with the DPS, develop a detailed sustainability strategy that includes objectives, indicators and a monitoring plan and begin to implement it as soon as possible. As part of this plan, develop a capacity-building plan, which can also be monitored.

3. As part of this plan, work with the DPS to define a more substantial role for health agents and to increase their understanding of and ability to execute the Hearth model and quality of supervision of CAs.

4. As part of the continuation application, USAID should require a detailed capacity-building strategy, sustainability table and a logical framework.

5. Africare should begin to develop a follow-on project proposal no later than March 2000 for submission to BHR/PVC in December 2000.

6. Work with the DPS to add a quality of service delivery assessment to the semiannual monitoring exercise. This could be an observation of service delivery using the client-oriented, provider efficient services (COPE) or Basic Support for Institutionalizing Child Survival project (BASICS) observation instruments (or the ones used by the Population Council).

7. Review and revise project objectives and indicators related to MOH strengthening efforts to better reflect the project's efforts and capabilities.

8. When work with the development committees begins, community support of the CA should be one of the first subjects of discussion.

VI. TECHNICAL AND ADMINISTRATIVE SUPPORT

A. TYPES AND SOURCES OF EXTERNAL TECHNICAL ASSISTANCE

Table 9 shows the types of technical assistance that the MCHI has received, including the provider, technical area of assistance, and dates and benefits of assistance.

Table 9: Technical Assistance Received by MCHI

Person or Institution	Technical Area of Assistance	Dates	Benefits
Ms. Waverly Rennie	▪ Facilitated training of trainers ▪ Facilitated training in nutrition/communication	July 1998 July 1998	▪ Teambuilding between MCHI and DFSI staff ▪ Staff learned about appropriate and effective training facilitation and communication techniques ▪ Improved knowledge of health facility staff in nutrition
Dr. Hassane Fadiga (DPS) Dr. Djenabou Barry (DPS)	Assisted with training of field agents and MOH staff in CDD	January 1999	▪ Improved skills of MOH staff related to CDD ▪ Trained MCHI field agents in CDD
Dr. Fode Konate (MOH Institute of Nutrition)	Provided technical advice regarding the Hearth model	March 1999	▪ Helped the project identify simpler and less expensive recipes, promoted Hearth approach among MOH officials
Dr. Boubacar Diallo (MOH/NMCP) Dr. Louis Destephen (Donka Hospital)	Assisted with training of MOH/HC staff and project field agents in malaria control	July 1999	▪ Improved skills of MOH and project staff related to malaria
Mr. Jean Gozaka Kourouma and Ms.Hadja Binta Barry (AGBEF)	Assisted with training of MOH and MCHI project staff	September 1999	▪ Improved skills of MOH and project staff related to reproductive health, particularly family planning
Dr. Grethchen Berggren Ms. Waverly Rennie	Helped facilitate national workshop and provided technical assistance on the MCHI Hearth approach	October 1999	• Strong advocacy at national, regional and prefectoral levels for MCHI Hearth approach • Documented feeding behavioral changes among Hearth participants and impressions of husbands • Provided suggestions on improving the approach • Pretested the video on MCHI Hearth approach

B. TECHNICAL AND ADMINISTRATIVE SUPPORT RECEIVED FROM HEADQUARTERS

Technical and administrative support from Africare/Headquarters has been adequate, and the project appears not to have faced any constraints in receiving technical assistance in a timely manner. Technical support has been provided by Africare's health program manager through three visits to the project since its inception. The most recent visit was to attend the national workshop on the Hearth model in October 1999. Africare's West Africa regional director also visited the project in July 1999. He is planning another visit shortly to help orient the new MCHI project coordinator. In addition to visits from the headquarters' staff, the project is guided by the country director and the administrator who see project staff either in Dabola or in Conakry at least once a month.

In hindsight, it may have benefited the project to receive technical assistance to help develop an IEC strategy and an HIS/MIS system. These are two very specialized areas with which NGO project staff often need assistance. At this point in time, however, it is not clear who should have identified this need or if it appeared as a need at the time at all.

The project could use technical assistance to develop its sustainability plan and may need assistance if it proceeds with the income-generation component. An outside consultant will be engaged to lead the final evaluation but will probably be hired by USAID directly.

C. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. Technical assistance was provided in a timely manner and was considered beneficial.

2. The project would have benefited from technical assistance in the development of an IEC strategy and a health information system.

Recommendation

Technical assistance should be procured to help project staff and DPS develop a comprehensive sustainability plan.

VII. FINANCIAL EXPENDITURES

Table 10 outlines the project's budgetary situation at the time of the midterm evaluation.

Table 10: MCHI Budgetary Summary

Item	Amount in Dollars
Approved Project Budget	2,358,370
Expenditures through July 1999	942,035
Estimated Expenditures, August–Sept. 1999	108,179
Balance as of October 1, 1999	1,308,156
Proposed Expenditures Fiscal Year (FY) 2000–01	1,308,156
Anticipated Balance	0

Africare/Guinea maintains very comprehensive and understandable budget summaries and analyses, which are accompanied by a detailed budget narrative. Budget adjustments are signaled to USAID/Guinea each year in the annual report. At a monthly average expenditure rate of between $45,000–$65, 000, the project is expected to spend the remaining $1.3 million of its budget.

VIII. ACCOMPLISHMENTS AND CONSTRAINTS

A. CONSISTENCY OF PROJECT IMPLEMENTATION WITH THE CONTINUATION APPLICATION

It is assumed that the continuation application is similar to a Detailed Implementation Plan and similar to those prepared by BHR/PVC−funded child survival grantees. The continuation application, however, is not similar to the Detailed Implementation Plan. It is more similar to an annual report and does not set forth a narrative plan for project implementation. Therefore, it is not possible to assess the extent to which the project is consistent with the continuation application except perhaps to compare the work plan for the second year with what actually took place. This was provided in MCHI's annual report to USAID and appears here in annex G.

Neither the proposal nor the continuation application mentions the nutritional Hearth as a strategy to address malnutrition. This activity was added at the end of FY 1997, and the first Hearth activity was conducted in the first quarter of FY 1998 (December 1998). Because the project did not have a malnutrition indicator, it did not identify a specific strategy for addressing malnutrition. The project coordinator introduced this approach with assistance from a technical assistant who had prior experience with the Hearth model. Interestingly enough, this strategy may prove to be the most important contribution to improving health among Guinean children.

Project staff did not expect to become involved with mosquito-net impregnation and distribution. However, when the project coordinator approached the National Malaria Control Program (PLNP) team regarding training, Africare was identified as a welcome collaborator, and the PLNP decided to train a mosquito-net impregnation and distribution unit in Dabola with assistance from the project. Through its involvement, the project may help the development community answer some questions regarding the implementation of impregnated bed nets as a strategy to control malaria. In the area of malaria case management, the project's current intervention is limited to referral, because, unlike its neighbors, Guinea's MOH has not yet approved the treatment of malaria by community health workers. Given Africare's comparative advantage as an innovator, the prevalence of malaria and the difficulties associated with referrals, the ministry might want to consider piloting community-based case management of malaria through the MCHI.

Table 11 shows the extent of achievement of the project's outcome indicators, the basis upon which USAID judges performance (in addition to the work plan). Without the benefit of a Logical Framework, it is difficult to tell if these are the most appropriate outcome indicators. What is certain is that the means of verification (training post-test) of some of the indicators is not particularly valid since knowledge is expected to be high immediately after a training event. A more meaningful indicator would be related to practices and could be assessed by field agents during supervisory visits.

Table 11: Summary of Achievement of Project Outcome Indicators

Component	Activity	Expected Year 2 Achievement	Actual Year 2 Achievement	Comments
Nutrition	1. Number of Hearths created	80	20	
	2. Percentage of community health workers who know how to accurately weigh and interpret the weight on the community board	90%	81%	Achievement assessed at time of posttest
	3. Percentage of community health agents who understand the principle of frequency, adequacy, density, and utilization (FADU)	90%	76%	Achievement assessed at time of posttest
	4. Number of community health agents trained in nutrition	47	48	Would be more meaningful if this indicator related to a particular score on a training posttest
Control of Diarrheal Disease	5. Percentage of health center staff accurately able to cite the appropriate case management for diarrhea	70%	86%	Achievement assessed at time of posttest
	6. Percentage of community agents who cite continued/frequent feeding/breastfeeding as an important message to give to mothers whose children have diarrhea	90%	To be determined	

Component	Activity	Expected Year 2 Achievement	Actual Year 2 Achievement	Comments
Malaria	7. Number of insecticide-treated bed nets sold	To be determined	To be determined	

	8. Number of women's groups promoting and distributing impregnated bed nets	3	1	
	9. Number of community agents trained in malaria control	47	48	
Reproductive Health	10. Percentage of community agents who know the advantages of family planning in relation to maternal and child health	80%	To be determined	Project is waiting for PRISM to complete the reproductive health training curriculum before training the CAs
	11. Number of new acceptors of modern contraception	328	To be determined	Component has not yet begun
	12. Couple years of protection	To be determined	To be determined	Contraception distribution will begin only after CAs have been trained
	13. Percentage of districts covered by community agents trained by the project	70%	40%	Project expects coverage of 60% of Dabola by project's end.
MOH Expansion and Strengthen-ing	14. Number of new health posts constructed	1	0	Construction underway
	15. Number of health posts renovated	1	0	Renovations underway
	16. Percentage of health centers with adequately functioning cold chain equipment			Indicator eliminated because baseline data indicated that cold chain equipment had already been provided and was functioning well

B. ADHERENCE TO PROJECT SCHEDULE

As the work plan displayed in annex G indicates, there are a few activities that were not carried out when originally scheduled. These include the organization of community development committees, construction/renovation of health posts, provision of cold chain equipment, and implementation of income-generating activities. As mentioned previously, the project deliberately delayed creation of village health committees until it could better understand the extent to which other such committees already exist in the target areas. While thought to be essential to continued support of the community agent, the delay in creating these committees seems not to have hindered the project thus far.

The construction of health posts, which was supposed to begin in December 1998, was delayed by about 10 months while the exact location was negotiated, community participation generated, and the legalities of construction were met. The baseline data

survey conducted of the health centers revealed that cold chain equipment was available and functioning, so this activity was eliminated from the project plan. Implementation of income-generation activities has been delayed for several reasons: project staff has been very occupied with Hearth activities and the national workshop held in October, project staff wanted to study potential partners and their ongoing activities before proceeding, and additional staff was needed to handle this and the community development committee aspects of the project (it was decided to wait until that person was hired before proceeding further). Training events have also been rescheduled to accommodate workloads.

The project has also been involved with activities that were not originally programmed but which have enhanced the project and its contribution to primary health care in Dabola. These include Hearth activities and the national Hearth workshop, field worker assistance on national vaccination days, participation in the Regional IEC Working Group; and participation in the semiannual MOH monitoring activities.

C. PRIMARY ACHIEVEMENTS

Addressing Malnutrition¾ The Hearth Model

Innovative Work: Capitalizing on its comparative advantage as an NGO, MCHI/Africare has undertaken innovative work with the Hearth model, an approach that addresses malnutrition at the community level. Through this method, 84 percent of the 140 children present at the second post−Hearth weighing had been rehabilitated and mothers had begun to adopt feeding behaviors that should prevent malnutrition from recurring.

Advocacy: As a result of Africare's organization of a national seminar on the Hearth model, many other NGOs and ministries have become aware of the method and it has quickly become a potential model approach for malnutrition recuperation among other NGOs, such as Plan/Guinea, Adventist Development and Relief Agency International (ADRA), and Action against Hunger.

National Application: More importantly, the Hearth model has the potential of becoming a means for the MOH to reduce malnutrition rates nationally. In the fourth year of the project, Africare will work with the DPS of Dabola to determine how the Hearth model can be adapted so the DPS can implement it as part of its own community-based strategy.

Increased Access

The MCHI project has increased access to PHC services by

- promoting collaborative efforts between community agents and MOH health workers so that more people take part in community-level health activities conducted by health center staff, such as vaccination days;

- training 48 community agents in nutrition, malaria control and prevention, diarrheal disease control, reproductive health, and IEC skills;

- implementing growth monitoring and Hearth activities to identify and rehabilitate malnourished children;
- constructing and renovating health posts;
- providing motorcycles to MOH agents;
- supporting and supervising community agents;
- developing a referral system;
- improving the emergency evacuation system from health posts to hospitals through the provision of radios to health posts; and,
- working with UNICEF to develop a community-level emergency evacuation system.

Integration and Coordination

MCHI/Africare has developed an excellent working relationship with the DPS and other organizations operating in the area and effectively coordinates its work with these entities. For example, MCHI is:

- working with the UNICEF/Maternity without Risk Project to develop an emergency evacuation strategy to complement the project's provision of radios to the health centers;
- working with PRISM and 13 other organizations to standardize and share approaches to IEC in the region;
- working with PRISM, AGBEF and PNLP to standardize the training of health agents;
- providing information to PRISM's community-based strategy coordinator to standardize community-level data gathering and supervision instruments; and,
- serving as a resource to other NGOs interested in initiating the Hearth model.

Increased Quality

MCHI/Africare has increased the capacity of community agents to provide quality care in support of maternal and child health through training and support. It has developed monitoring instruments to track inputs and outcomes, and are advocating for better support and recognition of community-level health activities.

D. IMPEDIMENTS TO PROJECT PROGRESS AND OVERCOMING CONSTRAINTS

Understaffing in Health Centers

At present, most of the health centers are understaffed. The person most often responsible for community activities is also responsible for the vaccination program and this person is particularly busy. Health agents have little time to dedicate to supporting community agents, such as providing supervision as well as formal and on-the-job training.

To address this, the field workers visit the health centers several times a month, on average, and have developed other mechanisms to keep the health agents informed about community activities. The project has also provided six motorcycles to health centers to facilitate access. In the long term, the problem will be solved when additional staff is recruited (a process that the DPS has already set in motion) and assigned responsibility for community activities.

Little MOH Incentive to Support Community Activities

Not only is staff limited but the MOH does not provide any incentives to health agents to support community activities. No data or other information is collected related to community agents' work. As a result, health agents understand that the MOH/DPS is not particularly interested in these activities.

UNICEF has been supporting the advocacy efforts of the MOH's nutrition unit so that nutrition indicators will be included among the others used by the Ministry of Health and progress is apparently being made. Until then and to place more importance on community activities, the Dabola DPS should require all heads of health centers to collect and report on community activities during the semiannual monitoring meetings.

Health Center Quality of Care

While the PRISM/Population Council report clearly indicated the lack of quality of care in health centers, given its current staffing pattern, other than training, the project has no mechanism through which it can directly affect on the quality of service delivery at the health-center level.

Because both PRISM and GTZ are focusing on improving quality of service delivery, and given the already overburdened workload of project staff, MCHI has placed less emphasis on improving the quality of care provided by health center staff than at the community level, where Africare's comparative advantage lies. During the second half of the project, MCHI would do well to leave the majority of this responsibility to PRISM and GTZ. Should the DPS implement the COPE approach (a self-assessment of quality of care), which appears likely, then the doctors employed by the project might be useful in helping to train heads of health centers in the execution of this approach.

Widely Dispersed Population

The population of Dabola is widely dispersed and does not live in concentrated population centers (villages) as in much of West Africa. This means that one community agent has to travel to several different locations, which can be many kilometers apart, to reach her/his target groups. For example, to weigh all of the children under age 3 in her/his target area, each community agent needs to spend up to five mornings per month. There may only be 15–20 children in any one community. This is very time consuming. This dispersion also makes it difficult for one community agent to provide other services, such as ORS packets and timely health education. The Hearth model is also affected by this phenomenon, making it necessary to identify a *maman lumiere* who lives more or less equidistant (and not more than 2–3 km) from the participants. This is a major logistical challenge.

To address this situation, the project has provided bicycles to each community agent and has tried to define target areas taking the terrain, population location, and other factors into consideration. The project also recognizes the extra strain this places on the community agents and provides substantial support and encouragement to them.

E. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. The continuation application is not a substitute for a Detailed Implementation Plan and is not useful in determining consistency of project implementation.

2. The second year annual report contains much of the information required to be reported on in this midterm evaluation.

3. For the most part, the project is being implemented on schedule. The formation of community committees and the implementation of income-generating activities are the two components that are quite behind schedule. There may not be enough time to execute the income-generation component satisfactorily.

4. The project's most important achievement is the successful pilot testing of the Hearth model.

5. The most serious constraint to the project is the MOH's limited official recognition of the importance of community-based activities.

Recommendations

1. Project staff needs to develop a complete Logical Framework for the project, identify the outcome indicators, and use these to monitor and report on project performance.

2. USAID should require grantees to develop a Detailed Implementation Plan once the baseline data have been collected. Alternatively, the format of the continuation application could be changed so that it looks less like an annual report and more like a Detailed Implementation Plan.

3. In years when there is a project evaluation, USAID should not require the project to write an annual report.

4. Project staff should continue to implement the Hearth model, always looking for ways to more effectively and meaningfully incorporate the health agents into the program. Also, the staff should continue to share lessons learned with partners and other NGOs trying the approach.

5. Project staff should ask the DPS to require the heads of health centers to collect and report on community activities taking place in their subprefecture.

IX. ISSUES IDENTIFIED BY THE EVALUATION TEAM, NGO OR USAID

A. PROJECT EXPENDITURES

USAID raised the issue of whether the project could spend all of its money. As discussed in chapter VII, at its current expenditure rate of $45,000–$65,000 per month, the project will definitely spend its entire grant.

B. COORDINATION/COLLABORATION BETWEEN DFSI AND MCHI PROJECTS WITH REGARD TO THE VILLAGE HEALTH COMMITTEE STRATEGY

USAID is concerned that MCHI will have difficulty merging the Dabola approach (initially no community committees) with that of the DFSI/Dinguiraye approach where the project started out establishing committees. In as much as MCHI/Dabola has now decided to form development committees, this is not a problem. In fact, MCHI could benefit from the lessons learned in the DFSI project with regard to the formation of committees and use these lessons to improve the approach and increase support for the community agent.

C. REDUCED BUDGETARY SUPPORT

Africare is concerned that there could be a USAID budgetary shortage. The evaluation team discussed this issue with the project staff and came up with the following suggestions on how reduced budgetary support could be handled:

- Do not train a third cohort of community agents in Dabola—concentrate on current activities;
- Do not implement the bed net impregnation component and do not import mosquito nets; and,
- Do not implement the income-generation component.

None of these scenarios is particularly helpful without knowing exactly how much money USAID would withhold from the project. Since costs are integrated into line items, Africare would have to do a specific analysis to determine the financial impact of each scenario.

D. ROLE OF CONTINUATION APPLICATION

The format of the continuation application is presented in the grant agreement with Africare (pages 8–9) and stipulates that changes to the original proposal should be presented in the continuation application. However, it was difficult to determine the

precise role of the continuation application as this is a rather new concept in project funding. The scope of work used the term "continuation application" as if it were the same as a Detailed Implementation Plan, a document required by the BHR/PVC–funded child survival grant that describes the project in great detail and clearly takes the place of the proposal, once approved. The continuation application, however, does not provide the same degree of detailed activity description, explanation and justification for changes as a Detailed Implementation Plan, and therefore was not useful in the assessment of such things as outcome indicators, sustainability or consistency of approach.

The main issue is that there is no single project document that clearly describes and justifies the project's current approach and implementation of such activities as the Hearth and mosquito-net impregnation. The absence of this document is a major impairment to project implementation and support efforts.

ANNEXES

ANNEX A

SCOPE OF WORK
(from USAID/GUINEA)

1.1 Background

USAID/Guinea's health program currently targets the public and private sector. Under the public sector activity, a four years Community Based Maternal and Child Health grant was awarded to Africare in September 30, 1997 to cover the prefectures of Dabola and Dinguiraye in Haute Guinea. The implementation of the grant activities will start in Dabola first and then will move to Dinguiraye during the last 2 years of the grant. As a requirement under the grant agreement, USAID/Guinea will conduct a mid-term (MT) evaluation and hence seeks assistance in analyzing the current status of the community based Maternal and Child Health (MCH) initiative in terms of achievement of proposed results.

Specific objective of the MCH initiative is to reduce maternal and child morbidity and mortality in the prefectures of Dabola and Dinguiraye through nutrition improvement, diarrhea disease control, malaria control and safe motherhood/family planning. The project targets 46,000 children under 5 years and 46,000 women of reproductive age under the two prefectures.

The proposed activity contributes directly to the Mission's health objective "increased utilization of FP/MCH and STI/AIDS prevention services and products" and four intermediate results notably Increased Access, Improved Quality and enhanced demand for FP/MCH and STI/AIDS prevention products and services and more effective response among donors and community organizations, NGOs in addressing critical health constraints. The activity equally meets the expressed desire of Guinea's Ministry of Health to work in the area of maternal and child health in those two prefectures characterized by high maternal and child mortality rates.

This MT evaluation will cover activities implemented in Dabola from September 97 to September 99. The total population in Dabola is 110,975 and the project targets 23,000 children under 5 and 23,000 women of reproductive age. Dabola has 6 health centers and 4 health post integrated in the EPI/PHC/ED program as well as FP. There is also one hospital in Dabola. As a community based activity, the project works with community health agents, village leaders and elders, existing community organizations and religious leaders to implement its maternal and child health interventions. Collaboration with other USAID programs, the MOH and other donor's activities in the area is also an important aspect of this activity.

Existing Performance Information Sources

1. Activity Proposal

2. Quarterly Reports

3. Baseline quantitative and qualitative studies

4. Grant Continuation application

5. USAID/Guinea Strategic Plan

6. USAID RA's

7. USAID 1998 & 1999 PRA reports

8. SO2 strategic Framework and revised indicators

9. MOH and other Donors/partners in the area

10. Beneficiaries/the population

11. Other documents as required

1.2 Purpose

The purpose of the mid-term evaluation is to identify what is working well, identify barriers to achievement of goals and objectives, review expenditure levels of the past two years of project, suggest areas which need further attention and recommend useful actions to guide the staff through the last half of the project. The evaluation should equally assess the extent to which field project implementation is in accordance with the continuation application. Any substantial changes in the project's beneficiary population, interventions, objectives, site or principal partners, since the time of the work plan and the reasons for these modifications should be described.

USAID/Guinea will use information provided to make budget and program decisions needed for future planning. The evaluation results are needed by December 30, 1999.

1.3 Description of the Contractor's Services

The Contractor's task is described in A through H below:

A. QUALITY OF PROGRAMMING

Describe the relationship of this project to other health-related activities in the project area (including those of this and other PVOs, NGOs, private and traditional health providers, government and donors). Discuss the role of the project in relation to the area's health facilities and referral care sites, and linkages between these facilities and the communities served by the project. Briefly discuss any duplication of effort or services.

Comment on the level of access of mothers and children to the health facilities associated with the project, and to other project-related providers of child survival services including community health agents identified and trained by the project.

List (in a table if desired) the titles and numbers of all categories of project staff and of other personnel with whom the project is working (voluntary and paid, including government and NGO staff), identify the organization for which they work, and note their main roles in relation to the child survival project.

List the frequency of contacts for support and supervision of all categories of project-associated health workers and facilities providing child survival services, and the ratios of supervisors to those being supervised.

Comment on whether the numbers, roles, and workload of personnel and frequency of supervision are appropriate for meeting the technical and managerial needs of the project.

B. QUALITY AT THE COMMUNITY LEVEL

Has the project defined specific messages for each MCH interventions that are culturally appropriate? Are these messages technically up-to-date? How and when are the messages communicated to members of the community? Have any essential messages been omitted?

How has the project assessed understanding of messages or levels of knowledge or practices, what have been the findings of these assessments and how has the project used this information?

Discuss your conclusions regarding the project's effectiveness in reaching the site's population (in terms of geographic location, age/gender, and risk status) with communications and other child-survival services. If any groups are probably not being reached, then please discuss why this is the case.

C. QUALITY OF HEALTH WORKER AND FACILITY SERVICES

List the tools used by the project to promote quality of service (such as: guidelines, training curricula and manuals, protocols, algorithms, performance standards, and supervisory checklists, etc.), and briefly describe how these tools are being used to assure quality or assess performance.

Discuss the extent to which the project has identified essential materials and supplies for each type of health workers including community health agents (AC) identified and trained by the project and facility, how effectively the project has monitored supply levels since the start of intervention activities, and actions the project has taken to correct any deficiencies.

Assess the knowledge, skills, practices, and supplies of health workers and AC and facilities associated with the project.

Discuss your conclusions regarding the effectiveness of project-related training, support, monitoring, and supervision in promoting quality service delivery by each type of health worker and facility associated with the project.

Describe the extent to which the project is using and supporting government or information system has been set up, and if set up, how much of the data being collected is other existing data collection systems, the extent to which an independent project-specific health being used to manage and monitor the project.

D. CAPACITY BUILDING AND SUSTAINABILITY

Describe the project's plans and progress in increasing the capacities of partner organizations and promoting the sustainability of child survival activities and/or benefits.

E. TECHNICAL AND ADMINISTRATIVE SUPPORT

What are the types and sources of external technical assistance the project has received to date, and how timely and beneficial has this assistance been?

Discuss the technical and administrative support from the PVO regional or central offices in relation to the needs of field staff, and any constraints the project faces in obtaining this support.

F. FINANCIAL EXPENDITURE

Assess activity's current budget expenditures and project funds needed for the remaining life of project.

G. ACCOMPLISHMENTS AND CONSTRAINTS

Please provide a thorough discussion of the extent to which actual implementation of each child survival intervention is consistent with the annual (98) grant continuation application, and whether all essential elements of each intervention are being addressed by the project and its partners.

Briefly discuss the extent to which the overall project is being implemented on schedule, as planned in the annual (98) grant continuation application.

Briefly describe the most important achievements of the project to date. What factors have contributed the most toward the achievement of progress?

What factors have impeded progress, and what actions are being taken by the project to overcome these constraints?

H. ISSUES IDENTIFIED BY EVALUATION TEAM, PROJECT, OR PVO

Did the evaluation team, project staff, or PVO headquarters identify any other questions to be addressed by the midterm evaluation? If yes, then please discuss these issues.

Evaluation Method

USAID/Guinea is requesting a participatory evaluation. As such, the mission requires the participation of projects staff and representatives from project partners and stakeholders in planning and conducting the evaluation, including PVO country office and headquarters, government health services, NGOs, and community members. The consultant will be responsible for reviewing the scope of work and developing a participatory action plan for the evaluation. The consultant will review the plan with USAID/Conakry prior to conducting the evaluation. Upon completion of the evaluation, the consultant will be responsible for preparing a formal presentation to USAID/Guinea, Africare as well as the MOH. A draft report of the evaluation in English is required. USAID/Guinea will review the draft and provide comments while consultant is still in country. Within two weeks of receiving these comments, the consultant will provide USID/Guinea with a final report. The Contractor shall also submit a French version of the report to USAID/Guinea one-month after the Contractor submits the final report to USAID/Guinea.

In order to conduct the evaluation, the consultant shall:

Review available documents
Conduct interview with USAID/Guinea, MOH (central and regional staff)
PSI/OSFAM, PRISM, Africare local staff, beneficiaries
Conduct field visits
Conduct qualitative research

Any additional methods the consultant finds appropriate to complete the mid-term evaluation need to be discussed with USAID/Guinea Health Team.

The evaluation team leader/the consultant should be someone who is not employed by, or otherwise professionally associated with the concerned PVO or child survival project. This person will be identified or must be approved by USAID/Guinea SO2 prior to the evalutation. This person should be a child survival specialist with extensive five to ten years experiences in community based activities in developing countries as well as experiences in conducting participatory evaluations. The incumbent will have FS-4 level oral and written skills in French and English.

1.4 Reporting and Dissemination Requirements

The final evaluation report should be in English and in French. The consultant will be responsible for providing five copies of the report in English and five copies in French. A diskette should be provided for each report in MS Word.

The mid-term evaluation report should:

Provide an executive summary

Summarize the highlights of the midterm evaluation, including:

Evaluation methods, sites visited, and dates of field work,

Main "Accomplishments and Constraints" of the project, and conclusions regarding the extent to which implementation is consistent with the project's approved work plan. Main conclusions regarding the "Quality of Programming", "Quality at the Community Level", and "Quality of Health Worker and Facility Services" (from sections 3, 4, and 5).

Present the recommendations of the evaluation. For each recommendation:

Discuss the problem or concern identified by the evaluation,

Recommend the action(s) to be taken,

Identify the organization(s) which should implement the recommended action (field project, PVO headquarters, etc), and

Suggest the date by which the recommended action should be implemented.

Appendices will include:

Scope of Work
Documents consulted
Name, title, and institutional affiliation of all members of the mid-term evaluation team, and all authors and editors of the evaluation report. Include the resume/CV of the evaluation team leader/the consultant.
Sites visited

ANNEX B

QUESTIONNAIRES AND DISCUSSION GUIDES

Questionnaire pour les Agents Communautaires

General

1. Quels sont les objectifs du projet ISMI?
    a) Ameliorer l'etat nutritionelle (allaitement immediate/exclusive, FADU)
    b) Aider les meres a gerer les cas de palu
    c) Reduire les cas de diarrhee
    d) Promouvoir l'utilisation de la SRO
    e) Autres _____

2. Quels sont les activites que vous effectuez avec le projet ISMI?

3. *Oh ! c'est beaucoup d'activites!* Que fait votre communaute pour vous aidez dans vos autres activites quotidiennes?

4. Quels sont les comportements sanitaires chez les femmes que vous cherchez a changer?

5. Quels sont les etapes a suivre au cours de la pesee?
    a) correct et complet = bon accueil; faire deshabiller l'enfant; verifer si la balance est tarer; proceeder a la pese de l'enfant; communique la poid de l'enfant a la maman; faire l'interpretation sur le tableau communautaire; faire un feedback a la mere par apport a la chemin de la croissance; donner la conseil a la mere; pour les cas sur la rouge, referer l'enfant au CS/PS ; donner le date pour la prochian rendez-vous
    b) incomplet

6. Pendant la pesee, a qui donnez-vous le conseil?

7. Est-ce que vous pouvez nous montrer vos outils de gestion et materiel IEC?
    a) registre
    b) cahier de rapport mensuel
    c) cahier de reference
    d) fiches de croissance
    e) affiche Vit A
    f) poster allaitement
    g) boite a image LMD

8. Combien d'enfants de moins de 3 ans avez-vous enregistrer dans ce village?
    _____

9. Parmi ces enfants combien ont ete pesee le mois d'Octobre?

10. Combien de ces enfants etaient bien nourri? _____

11. A quoi sert le registre?
    a) connaitre le nombre d'enfant d'etre pesee
    b) suivre la croissance de chaque enfant
    c) suivre les enfants de foyer
    d) suivre les cas de reference
    e) identifier les cas de deces

12. Quels sont les messages du projet destine aux femmes enceinte?
    a) allaitement immediate
    b) allaitement exclusive
    c) prophylaxis pour le palu
    d) assister au consultation CPN
    e) autres _____

13. Comment arrivez-vous a atteindre les femmes enceintes dans vos messages?

14. Avez-vous entendu parlez de foyer? OUI NON
    Si oui, quoi sert le foyer?

15. Quel est votre role dans le foyer?

16. Pensez-vous capable de gerer un foyer seul? OUI NON
    si oui, quels sont les etapes a suivre?
    a) pendant le pesee, identifier les enfant malnutris
    b) identifier les Mamans Lumieres et les maman participants
    c) identification des recettes
    d) enquete de marche
    e) negocier avec la manan Lumiere et les participants
    f) formation ML
    g) execution du foyer pendant 12 jours
    h) suivi post foyer

17. Avez-vous des sachets de SRO disponible? OUI NON

18. A partir d'ou vous vous approvisioner en SRO?

19. Pendant les dernier six mois, y-a-t-il eu une rupture de stock en SRO? OUI NON

20. Combien de temps la rupture en SRO a duree? _____

21. Combien de SRO avez-vous vendu pendant le mois d'Octobre? _____

22. A quel prix vous les avez vendu? _____

Supervision

23. Qui est votre superviseur? _____

24 .Votre superviseur vous rendre des visite de supervision avec quel fréquence?
- a) Each month
- b) Once every 3 months
- c) once every 6 months
- d) _____

25. Quand est-ce que votre superviseur vous a rendu en visit de supervision pour le dernière fois? _____

26. Qu'est-ce qui c'est passe pendant sa visite?

27. Avez vous reçu du retro-information pendant/après sa visite? OUI NON
Si oui, sur quoi?

Agents Communautaire
Questionnaire de Connaissance

La Nutrition

1. Pourquoi pesez-vous les enfants?
- a) pour connaitre l'etat de croissance de l'enfant
- b) detecter les cas de malnutrition
- c) donner de conseil aux meres
- d) autres _____
- e) ne sait pas

2. Comment faites vous la difference entre un enfant mal nourri et celui bien nourri?
- a) par le pese (ses poids)
- b) autre _____
- c) ne sait pas

3. Quelle est l'importance du premier lait (colostrum) de la mere pour l'enfant?
- a) pour renforcer l'immunite de l'enfant/protoger contre les maladies
- b) develop l'intelligence de l'enfant
- c) creer l'affection entre la mere et l'enfant
- d) favorise la delivrance rapid du placenta
- e) favorise la secretion du lait
- f) autres _____
- g) ne sait pas

4. A quel age donner vous un autre aliment en plus du lait maternel à un bébé?
- a) correct = 6 mois
- b) incorrect

5. Quels sont les chemins qu'il faut suivre pour assurer une bonne alimentation de l'enfant?

a) correct/complet = allaitement immediate et exclusive, introduction des autre aliments des 6 mois; FADU
b) incorrect/incomplet

Le Paludisme

6. Quels sont les signes du paludisme face aux quels la reference est urgente?
   a) correct et complet = corps très chaude; secousses violents de tout le corps ; perte de connaissaice; urine chocolatee (coka)
   b) incorrect/incomplet
   c) ne sait pas

7. Que doit faire un agent communautaire devant un enfant qui a le paludisme?
   a) correct = envelopper l'enfant, référer l'enfant au Centre de Santé ou Poste de Santé
   b) incorrect/incomplet
   c) ne sait pas_____

8. Le paludisme est plus dangereux chez qui?
   a) correct/complet les enfants 0-5 ans, les vieilles personnes, les femmes enceinte
   b) incorrect/incomplet
   c) ne sait pas_____

9. Quelles sont les mesures qui protegent contre le paludisme?
   a) correct/complet : dormir sous une moustiquaire, assainir l'entourage ; donner chaque mois de la choloroquine aux femmes enceintes
   b) incorrect/incomplet
   c) ne sait pas_____

Contrôle des Maladies Diarrhéiques

10. Quels mesures peuvent protéger quelqu'un contre la diarrhée?
    a) vaccination contre la rougeole, utilisations de latrines, bonne préparation et bonne conservation des aliment, allaitement immédiat et exclusive (0–6 mois)
    b) incorrect/incomplet
    c) ne sait pas

11. Que doit faire une mère pour soigner un enfant avec le diarrhée?
    a) continuer a allaiter, continuer a donner a manger plus que d'habitude, donner plus a boire que habitude, préparer et administrer le SRO
    b) incorrect/incomplet
    c) ne sait pas____

Communication Interpersonnel

12 Quels sont les qualités d'un bon message?

a) correct/incomplet- simple, clair, precis, faisable,
b) incorrect/incomplet
c) ne sait pas

13. Quels sont les qualités d'un bon communicateur?

a) être patient
b) donner le pouvoir (la parole) a tout le monde
c) être respectueux des coutumes du milieu
d) autre _____

14. Quels sont les obstacles lies a la bonne communication? (au moins 4 response)

a) les mots trop difficiles/complique
b) le ton non respectueuse
c) la langue n'est pas du milieu
d) l'émotion - manque de confiance de parler en public
e) le niveau d'instruction - utilise les images pour passer les messages
f) culture de l'auditoire - prendre en compte des réalité socioculturel
g) la différence de sexe - ne melange pas les sexes
h) les coutumes du milieu - jamais critiquer les coutumes
i) l'attitude - AC doit avoir une attitude respectable
le temps/climat

Nom de l'enqueteur _____ Lieu _____

Questionnaire pour les Meres

Introduction

Nous sommes ici pour discuter avec vous les activites sanitaires

Questions Generals

1. Quelles sont les activites sanitaires qui sont menes ici?

2. Avez-vous un agent communautaire ici? OUI NON

3. Si oui, quels sont ses activites?

4. Que pensez vous de son travail?

5. Que fait la communaute pour aidez l'AC dans ses activites quotidiennes?

6. Participez-vous a la pesee? OUI NON
   si oui, pourquoi? (A quoi sert la pesee?)

7. Quel est l'avis de votre mari par rapport a la pesee?

8. Jusqu'a quel age l'enfant doit etre pesee?
   a) 3 ans
   b) autre
   c) ne sait pas

9. (*Demandez a la mere de vous montrer sa carte de croissance de son enfant.*) Pouvez-vous m'expliquer ceux qui se trouve sur la carte (sa sense)?
   a) Identified la courbe de poid
   b) Donner l'interpretations des couleur
   c) Type de courbe
   d) (*qu'est-ce que la courbe nous dit sur l'etat de votre enfant*?) (le poid) de son enfant (bonne ou non)
   e) si la poid a augmenter ou diminuer depuis la dernier fois
   f) ne sait pas

10. Avez-vous participe aux autres activites mene par l'AC. OUI NON
    si oui, lesquelles?
    a) vad
    b) caueries en groupe
    c) strategie avance/vaccination
    d) foyer

e) activites d'hygiene
f) autres _____

11. Avez-vous entendu parlez du foyer? OUI NON
si oui, qu'est-ce que le foyer?

12. Pensez-vous qu'il y a des changements dans l'etat sanitaire des enfants depuis que l'AC a commence son travail? OUI NON
si oui, quels sont ces changements?

Connaissance

L'allaitement Maternel

13. Qu'est-ce qu' une mere doit donner a son nouveau ne immediatement apres sa naissance?
a) Correct = lait maternel
b) Autre
c) Ne sait pas

14. Est-ce que vous connaissez le colostrum? OUI NON

15. Quel est son importance?
a) pour renforcer l'immunite de l'enfant/protoger contre les maladies
b) develop l'intelligence de l'enfant
c) creer l'affection entre la mere et l'enfant
d) favorise la delivrance rapid du placenta
e) favorise la secretion du lait
f) autres _____
g) ne sait pas

La Diversification Alimentaire

16. Quand est-ce une mere doit adjouter d'autre aliments que le lait maternel?
a) Correct = au eme mois
b) ne sait pas
c) incorrect

17. A partir de six mois que doit manger un enfant?
a) lait maternel, bouillie enrichie, et jus de fruit
b) incorrect
c) ne sais pas

18. A partir de 6 mois, combien de repas un enfant doit recevoir pour etre an bon sante?
a) 4-6 repas par jour
b) incorrect
c) ne sait pas

Hygiene

19. Que doit faire une mere pour eviter la diarrhee?
    a) laver les mains avec l'eau and de la savon avant de manger
    b) utiliser les latrines
    c) laver ou cuire les aliments cru avant de les manger
    d) autres _____
    e) ne sais pas

Palu

20. Quel est la cause du palu?
    a) les piqure des moustiques
    b) incorrect
    c) Ne sais pas

21. Comment proteger contre le palu?
    a) eviter les piqures
    b) utilise un moustiquaire
    c) ne sait pas

22. Qu-est-ce qu'on doit faire quand un enfant a la fievre?
    a) Voir l'AC
    b) envelopement humide
    c) l'amener au centre de sante/post de sante
    d) incorrect
    e) ne sait pas

La Diarrhee

23. Qu'est-ce qu'il faut faire pour un enfant qui a la diarrhee?
    a) donner le SRO ou TRO
    b) continuer a allaiter
    c) continuer a donner a manger plus que d'habitude pendant et apres
    d) ne sait pas

24. Ou procurez-vous des sachets de SRO?
    a) chez l'AC
    b) au centre de Sante
    c) chez l'agent de Sante
    d) boutique
    e) autre _____
    f) ne sait pas

24. A quel est prix?
    a) _____
    b) ne sait pas

Vaccination

25. Pourquoi vaccinez-vous vos enfants?
    a) pour les proteger contre les maladies
    b) incorrect
    c) ne sait pas

26. A quel age une enfant doit etre completement vacciner?
    a) 1 ans
    b) incorrect
    c) ne sait pas

27. Une femme en grossesse doit etre vacciner combien de fois?
    a) 2 fois
    b) incorrect
    c) ne sait pas

Questionnaire pour les Agents de Terrain

Brief introduction of each person with a little background information–education, prior experience, languages spoken

General Questions

1. By component, what does your work for ISMI entail? (What do you do?)
2. How many ACs are you each responsible for?
3. Is this ratio enough, too much, too little? Explain?
4. By project component - nutrition, palu, diarrhea, FP–What does the AC's work entail? (How much time are they supposed to work each week?)
5. Taking each of their tasks separately, what are the AC's strong points? What are their major weaknesses?
6. How do the ACs raise awareness among the mothers?
7. How often do you visit each AC?
8. What do you do during a typical visit?
9. Do you supervise AC?
10. What does your supervision entail?
11. Do you have a supervision form (checklist) to guide you or to complete? (Have a look at several)
12. By what criteria do you judge if an AC is working well?
13. What is done with the supervision forms? How are they used? By you, by your supervisors?
14. What is the distance between the AC's and the villages they cover (how long does it take the AC to travel to his furthest district/village?)
15. What are the project's key health messages? What behaviors does the project seek to change among mothers?
16. Do you have a way to assess the effectiveness of ACs' IEC work? (That mothers are understanding the messages and changing behaviors?)
17. What information do the ACs provide you with each month? (Monthly report)
18. What do you do with this information? How is it used, by whom?
19. Is this information shared with anyone outside the project? (Head of Health Center, DPS)
20. How would you describe the rapport between yourself and the health center staff (agent de sante)?
21. What contact do you have with them? What about? Regularity?
22. How often do the AS visit the AC at their sites?
23. How often do the ACs visit the health centers for supervision?
24. Do you feel qualified to do your work? Have guides and manuals to help them do their work, so they feel pretty comfortable?
    Has the training provided by the project adequately prepared you to do your work? Any deficiencies? Does anything else need to be done?
25. Of the activities/benefits brought about through the project, which ones do you think will be continued after the life of the project? How? By whom?

What needs to be done to make sure the benefits, if not the activities, will continue after the project? The activities of the AC need to be coordinated with the AS.

26. What are the primary achievements of the project thus far?
27. Do you think the AC can take charge of the FARN on their own?

Les Questions de Connaissance

Control des Maladies Diarrheiques

1. Quels sont les signes de deshydration (non-grave) chez un enfant?
    a) agite, irritable
    b) yeux enfonces
    c) adsentes de larmes
    d) bouche et langue seche
    e) assoiffie, boit avec avidite
    f) pli cutane s'efface lentement
    g) ne sait pas

2. Quel est la prise en charge d'un enfant avec les signes de deshydration cite en haut. (Plan B).
    a) Peser l'enfant
    b) Prendre l'age de l'enfant
    c) administration de SRO (quantite selon l'age)
    d) pendant quartre heures
    e) re-evaluer l'etat de l'enfant apres 4 heures
    f) ne sait pas

3. Qu'est-ce que un Agent Comunautaire doit faire pour prendre en charge en cas de diarrhee aigue chez un enfant?
    a) faire boire a l'enfant plus de liquides que d'habitude
    b) donner a manger en abondance/un repas de plus par jour pendant 2 semaines/donner le sein frequemment
    c) amener l'enfant a l'agent de sante si'il ne va pas mieux apres trois jours
    d) ne sait pas

Paludisme

4. Quels sonts les signes de paludisme grave? (trois reponses neccessaire pour etre correct)
    a) douleur articulaire
    b) secousses violentes de tout le corps
    c) pertes de connaissances
    d) yeux enfonces
    e) paleur
    f) ne sait pas

5. Quel est le mode de prevention de paludisme chez une femme enciente?
    a) prendre le nivaquine jounaliere pendant sa grossese jusqu'a sixieme semaine apres l'acchouchement
    b) utilisation de moustiquaire
    c) ne sait pas

6. Pourquoi il est tres grave quand une femme enceinte a le palu?
    a) elle risque de perdre les poids/compromettre le developement de l'enfant
    b) faible poid a la naissance
    c) risque d'accouchement premature
    d) mort de la femme et son enfant
    e) ne sait pas

Sante de la Reproduction

7. Quels sont les signes evocateur d'une MST?
    a) correct et complet = l'ecoulement vaginale/uretrale, gonflement inguinal, ulceration genital, ophtalmie de nouveau ne
    b) incorrect

8. Quels conseil un Agent de Sante doit donner a malade suspecte avoir le virus VIH/SIDA?
    a) correct et complet = referer a une SC pour le test specifique; conseil l'utilistation des preservatifs; notifications des partener pour le depistage
    b) incomplet
    e) ne sait pas

9. Quels sont les contre indications absolues a la contraception hormonale?
    a) Thrombo-embolie
    b) Infections Vaginales
    c) Hepatite virale
    d) Mastalgie
    e) Ne sait pas

La Nutrition

10. Quel est l'avantage de la Vitamin A chez un enfant?

a) prevenir la cecite
b) prevenir les autres infections comme le rougeole
c) ne sait pas

11. Quel conseil un AC ou Agent de Sante doit donner a une femme enceinte sur l'allaitmentation de sont nouveau ne?
    a) allaitement immedaite
    b) allaitement exclusive
    c) ne sait pas

12. Quels actions une mere doit-elle entreprendre pour assurer la bonne sante de son enfant de mois d'un ans?
    a) Le faire vacciner completement
    b) allaitement maternal – immediat et exclusif
    c) l'introduction des autres aliments a partir de 6 mois?
    d) Ne sait pas

13. Combien de piqures il faut avoir pour qu'un enfant soit completement vacciner.
    a) cinq fois
    b) incorrect

14. Pourquoi il faut commencer a donner d'autre aliments en plus du lait maternel a un enfant de 6 mois?
    a) Pour augmenter l'apporte des autres nutriments essentiels
    b) pour qu'il apprenne a manger
    c) ne sait pas

15. Expliquez le principe de FQDU dans l'alimentation d'un enfant.
    a) correct = F
    b) incorrect

16. Quels sont les etapes qu'un agent communautaire doit suivre pour peser un enfant.
    a) correct et complet = bon accueil; faire deshabiller l'enfant; verifer si la balance est tarer; proceeder a la pese de l'enfant; communique la poid de l'enfant a la maman; faire l'interpretation sur le tableau communautaire; faire un feedback a la par apport a la chemin de la croissance; donner la conseil a la mere; pour les cas sur la rouge, referer l'enfant au CS/PS.
    b) incomplet

<u>Communication interpersonel</u>

17. Quels sont les qualites d'un bon message IEC?
    a) simple
    b) clair

c) precis
d) faisable
e) ne sait pas

18. Quels sont les commandements de la communication eficace?
    a) commander l'attention de groupe/individu
    b) clarifier le message
    c) offrir un message coherent
    d) inciter a l'action
    e) communiquer un avantage
    f) creer la confiance

19. Quels sonts les obstacles a la bonne communication? (au moins 4 de ces responses = correct)
    a) les mots trop difficiles/compliques
    b) le ton non respectueuse
    c) la langue n'est pas du milieu
    d) l'emotion – manque de parler en publique
    e) le niveau d'instruction, prendre en compte les realites socioculturelle
    f) culture de l'auditoire
    g) la difference de sexe
    h) les coutumes du milieu
    i) l'attitudes (non respect)
    j) le temps/climate

Project Staff (Senior Staff – Project Coordinator, Deputy and Supervisors)

A. Quality of Programming

1. In what ways does the MCHI work with other health-related development organizations in the project area? How does the project collaborate/share information/lessons learned with DFSI/ ISAD?

2. How does the project define adequate access to health services?

3. What percentage of the target population has access (according to this definition) to the health facilities supported by Africare/MCHI? According to the prefecture stats?

4. Is the project's work in building/renovating health posts related to improving access?

5. What is the status of the building/renovations?

6. To what extent will the construction improve access?

7. Do all project villages/districts have *agents communautaires*?

8. Explain the supervision strategy. Who supervises whom?

9. What is the frequency of supervisory visits? Monthly of AT.

10. What does supervision consist of?

11. What instruments are used?

12. What is the ratio of *agent de terrain* to *agents communautaires*?

13. What is the ratio of *agents communautaires* to population/district?

14. How often do ATs visit ACs? What do the ATs think of their workload? (Get job description for AT and ACs)

15. What is the AT's rapport with the MOH *agents de sante*?

16. Why did the census comprise 0-5 year old kids, when the project only weighs 0-3 year old kids? Can the percent of children 0-3 be calculated somehow?

17. What percentage of the sous-prefectures do you think the project can effectively cover? How will this be done?

B. Quality at the Community Level

18. What does the IEC strategy consist of? (How, when and by whom are key messages communicated to target groups?)

19. What does the project do to assess mothers' understanding/practice of the key messages? How do you use this information?

20. Does the project collect information about use of health facilities?

C. Quality of Health Worker and Facility Services

21. What instruments and tools are used by the project? (Get list)

22. Referring to the instruments and tools developed/used by the project – ask by whom are these tools used, and how? How do these tools help staff to make informed decisions? Give examples.

23. Essential materials and supplies table: What other materials might be needed? How are supplies/materials monitored? (Mustapha) supervision reports materials and stuff is checked.

24. How does the HIS work?

25. Who is in charge of the HIS?

26. Does the project use the MOH HIS or has it developed its own system?

27. How did the project decide what data to collect?

28. Does the project collect information on impact indicators as well as process/outcome indicators?

29. Does the project track inputs? Which ones?

30. What behaviors among the HC staff does the project seek to improve?

31. What is senior staff's rapport with Health Center staff? Regular contact?

D. Capacity Building and Sustainability

1. Does the project have a partner capacity building strategy? If so, what is it?

2. Does the project track institutional capacity building? If so, how?

3. Does the project have a sustainability plan? With objectives, indicators, activities, etc.?

4. What efforts have been made to get the *agents de sante* to take responsibility for training the AC?

5. What prevents them from participating in the AC training? Time/interest

6. What efforts have been made to get the *agent de sante* to supervise the AC?

E. Technical and Administrative Support

1. What TA has the project received thus far? (Table of external TA provided, including timeliness and benefit) How timely was this TA? How much did you benefit from this TA?

2. TA and support from Africare DC.

F. Accomplishments and Constraints

1. Is actual implementation of each CS intervention consistent with the grant continuation application? (Copy the chart from the annual report)

2. Have any of the activities been delayed (with relation to what was planned in the CA)

3. In your opinion, what are the most important achievements of the project to date? What factors have contributed to these achievements?

4. What factors have impeded progress, and what actions have been taken to overcome these?

G. Issues Identified by Evaluation Team, USAID or Project

1. What other issues do you want the evaluation team to look into?

ANNEX C

SUMMARY OF EVALUATION FIELD WORK

Summary Of Evaluation Field Work

Group 1: Bonnie Kittle, Gouley Cisse, Tadiba Kourouma

Subprefecture	District	#AC	Day
Dogoma	Kobolonia	Alpha Diallo + 3	November 10
Commune Urban	Kigneko	Moctar Barry + 3	November 11
ArphaMoussaya	Nyalen	Allasane Conde + 3	November 12

Group 2: Kadiatou Keita, Abdoulaye Diallo, Etiene Wendeno

Subprefecture	District	#AC	DAY
Banko	Souarela	Fode Souare	November 10
Kankama	Matiguila	Nyarra Traore	November 11
Bissikorouma	Demdeleya	Assatou Bah + 2	November 12

USAID/Conakry

Cathy Bowes, Health Unit Manager
Elizabeth Kibour, MCHI Project Officer
Miriama Bah

Africare Staff

Jonathan Lachnit, Country Representative
Michelle Ismering, Administrator

MCHI Project Staff

Agneiska Sykes, Project Coordinator
Gouley Cisse, Assistant Project Coordinator
Mustapha Grogovui, Supervisor/IEC/HIS/Trainer
Abdoulaye Diallo, Assistant Supervisor/Trainer
Field Agents (9)

Ministry of Health

Conakry
Dr. Macoura Olare, Nutrition and Food Division
M. Diallo and team, Malaria Control Program
Dabola
Dr. Yattara, DPS
6 Health Center Chiefs
4 Health Post Chiefs
16 Health Agents
17 Community Workers

Community Members

68 mothers

Project Partners

UNICEF Lina Mahy
PRISM Michael Blake and Elenore Rabelahasa
PSI William Stringfellow
GTZ David Blankhart

ANNEX D

PROJECT INDICATORS

BLD = Baseline Data
MTE = Midterm Evaluation

Project Indicators

Objective 1: To strengthen and expand existing government health services

Proposal Indicators	Continuation Application Indicators	BLD	Related MTE Data/Comments
90% of health personnel will have participated in MCHI-sponsored training courses			Africare was asked by USAID/Guinea to omit indicators related to the number of people trained by the project.
80% of health personnel will appropriately treat and/or refer childhood illnesses (diarrhea, malaria, malnutrition)			Recommended to be dropped officially since the GTZ project and PRISM are addressing this issue.
Six new health posts will be constructed	No. of new health posts constructed No. of health posts renovated	0 0	Three are under construction and likely to be finished before the end of the year.
80% of health facilities will have functioning cost recovery systems			Recommended to be dropped officially since the GTZ project and PRISM are addressing this issue.
90% of health facilities will submit accurate monthly reports on time			Recommended to be dropped officially since the GTZ project and PRISM are addressing this issue.
	No. of health centers with adequately functioning cold chain equipment	Indicated that no problem exists with the cold chain	Given the results of the BLD, this indicator was omitted.

Objective 2: To increase community capacity to take responsibility for their own health

Proposal Indicators	Continuation Application Indicators	BLD	Related MTE Data
Nutrition			68 mothers interviewed
30% of infants will be exclusively breastfed through 4 months of age	12% of infants exclusively breast fed through 6 months of age	2%	▪ 85% say that breast milk should be a newborns first food. 94% have heard of colostrum. 80% could correctly cite one advantage of colostrum
70% of mothers will be able to cite/explain appropriate weaning foods and practices	78% of mothers giving their children at the age of 6 months appropriate weaning foods in the form of porridge.	53%	▪ 73% know that a baby needs other foods by age 6 months;
70% of mothers will be able to cite energy-dense foods	47% of mothers giving their children ages 6-11 months protein-rich foods in the form of peanuts	27%	▪ 85% know what to first feed a six month old; ▪ 61% know that a six month old needs to be fed 4-6 times per day
80% of mothers will be participating in nutrition promotion sessions held in communities	Chronic malnutrition 21.5%	27.5%	▪ 100% were participating in the growth monitoring program
Malaria Control			
80% of mothers will be able to identify two malaria prevention techniques	50% of mothers able to identify at least one means of reducing the risk of getting malaria	20%	▪ 52% were able to identify at least 1 means of reducing the risk of getting malaria
70% of cases of fever in children will be treated with appropriate anti-malarial drugs	62% of children who had a fever in the last 2 weeks and were taken to a health facility	37%	▪ 77% knew to take a child with fever to the health center
70% of women will have used appropriate chemo-prophylaxis during last pregnancy	63% of mothers were given chemo-prophylaxis during their last pregnancy	38%	

Proposal Indicators	Continuation Application Indicators	BLD	Related MTE Data

CDD			
80% of mothers will be able to describe ORS and ORT	35% of mothers whose children had diarrhea in the last 2 weeks gave their child ORS	15%	73% knew to give ORS/ORT to a child with diarrhea
70% of mother will be able to describe appropriate preparation and administration of ORS	74% of mothers whose children had diarrhea in the last 2 weeks and who continued to breast feed the same amount or increased breast-feeding.	49%	
80% of mothers will be able to cite two methods of preventing diarrhea			
80% of cases of diarrhea will be treated appropriately with ORS/ORT in health facilities			
Safe motherhood/Family Planning			
70% of women will have had at least one prenatal visit (before 7th month) during last pregnancy	53% of women had at least 2 prenatal visits during their last consultation	33%	39% know that a pregnant women needs two TT vaccinations
5% of women aged 15-49 will report current use of modern contraception	7% of WRA report current use of modern contraception	2%	
Immunization			
60% of children will be fully immunized at 12 months (indicators for individual antigens to be added after KPC)	66% of infants who received a DPT 1 vaccine (demonstrating increased access)	41%	
	46% of infants 12 to 23 months who received DPT3 coverage	26%	51% know that a child should be completely vaccinated by 12 months of age

ANNEX E

SUPERVISION FORM

Fiche De Supervision Des Agents Communautaires ISMI/Dabola

Sous prefecture _____Date de supervision _____
District _____ Nom de l'AC _____
Secteur _____ Superviseur _____

* = renseignement que vous puvez prendre directement de fiches du rapport de l'AC

NO.		Non Ou Oui	Commentaires
	Verification des outils de gestion de des materiels		
1.	Fieche du rapport disponible?		
2.	Fiche de rapport correctement remplie?		
3.	L'agent dispose-t-il d'un materiel de travail complet? Identifier ce qui manque (balance, tableau, velo, etc.)		
4.	Les contraceptifs et SRO sont-ils disponibles et bien conserves?		
	Activities		
5.*	Pesee mensuelle executee?		No. des enfant pesees _____
6.*	Nombre d'enfants referes pour malnutrition		No. de Foyer:_____ No. de enfant ayant participe: _____
7.*	Y a-t-il eu un foyer pendant le mois?		
8.	Nombre d'enfant peses 4 semaines apres sa participation au foyer?		
9.	Nombre d'enfants vus pour diarrhee?		
10.*	Nombre d'enfants referes pour diarrhee?		
11.	Nombre d'enfats vue pour fievre?		
12.	Nombre d'enfants referes pour fievre?		
13.	Nombre des femmes vu en rattrapage actif?		
14.*	Y a-t-il eu des clients recu		No. des nouveau clients: ____

	pour PF?		No. d'anciens clients: _____ Preciser les produits vendue:
	Activites d'IEC/CIP		
15.*	Nombre des participants aux séance d'IEC		Nombre
16.	Preciser le ou les sujets abordes (N/LMD/CP/PF/H)		
	Observation Directe des Activities (0-2)		
17.	Apprecier le qualite des causeries educatives entre l'AC et les meres pendant les seances de pesee		
18.	Apprecaier le contenu des messages d'IEC transmis a la communaute		
19.	Apprecier l'AC entrain de communiquer a la communaute la preparation/l'utilisations du SRO		
20.	Apprecier l'AC entrain de communiquer aux femmes l'importance de l'utilisation de la chloroquine pour les femmes en grossesse		
21	Apprecier l'AC entrain de communiquer sur la PF		

22. Indiquer les facteurs qui ont facilite le travail ce mois pour l'AC.

23. Indiquer les difficultes recontrees ce mois par l'AC

AIDE MEMOIRE POUR l'AT

- *Faire la retro-information a l'AC et discuter sur les principaux resultats recueillis.*
- *Faire le rapport de supervision dans le cahier de l'AC (commentaire/recommendation en precisant la date).*
- *Preparer l'AC sur la verification de l'execution de ces recommendations lors de la prochaine supervision.*

- *Faire la retro-information (AT) a la coordination du projet (evoquer contraintes et les solutions).*

Supervision faite par _____Signature _____

ANNEX F

IEC MESSAGES PROMOTED BY MCHI
(TRANSLATED FROM FRENCH)

IEC Messages Promoted by MCHI
(Translated From French)

Breastfeeding

1. Put the child to the breast at birth so he/she benefits from the first milk. (Explain the importance of colostrum)
2. Mother's milk is the only nourishment that a child needs during the first 6 months of her/his life.

Varied Diet

1. From 6 months, mother's milk needs to be complemented by a richer and more varied diet:
   6 to 9 months: breastmilk + fortified porridge + fruit juice
   9 to 12 months: breastmilk + puree + semiliquid foods + fruit juices
   12 to 18 months: breastmilk + family's food + vegetables + fruits
2. From 6 months of age a child should be fed 4 to 6 meals per day
3. A good diet should be frequent, sufficient in quantity, well balanced and useful (FADU)

Hygiene

1. Always boil drinking water taken from wells, ponds and rivers.
2. To protect yourself from illness, one should wash his/her hands with soap and water before eating.
3. Wash or cook raw foods before eating them.
4. To avoid getting sick, one should use latrines and keep them clean.

Malaria

1. Mosquito bites give you malaria.
2. One should use a mosquito net to avoid mosquito bites which carry malaria (particularly children and pregnant women).
3. All pregnant women should receive chloroquine and iron tablets each month.
4. A child with fever, whether he coughs or not, should be immediately brought to a health center or post to get treated.

Diarrheal Disease Control

1. The medicine to use against diarrhea is ORS or ORT (home solution).
2. Health agents or community agents have ORS packets that they sell at reasonable prices.
3. A breastfeeding child with diarrhea should continue to be breastfed and given enough to drink.
4. A child with diarrhea needs supplemental feeding during and after her/his illness.

Growth Promotion

1. A child under the age of 3 years should be weighed each month to know his growth status.
2. The family and community should show interest and help with the growth monitoring and promote the growth of children with help from the community chart.

Vaccination

1. To be protected against childhood illnesses, all children fewer than 1 year ought to receive 6 vaccination in the health centers.
2. All pregnant women need to receive two vaccinations against tetanus.

ANNEX G

TIME LINE (YEAR 2)
OCTOBER 1998–SEPTEMBER 1999

Time line (Year 2)
October 1998–September 1999

X = the activity took place
0 = rescheduled for Year 3

Activities	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.
Training Field agents, health facility staff in malaria									X			
(1st group of CAs, first 6 villages) training in malaria control										X		
(2nd group of CAs, phasing in of 6 additional villages) 3 AS, training in nutrition and CDD							X	X				
Field agents, health facility staff in reproductive health												X
1st and 2nd groups of CAs, training in reproductive health											O	O
Supervision of Field Activities	X	X	X	X	X	X	X	X	X	X	X	X
Workshop Feedback on 3AS and IEC workshop for field agents	X											
Construction Preparation for construction/space renovation of health posts (assess the level of community participation)	X	X	X									
Construction and Renovation of Health Posts			O	O	O	O	O	O	O	O	O	O

Activities	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.
Provision of Equipment						X	X	X				

Start procurement process for health post equipment												
Microenterprise Research mircoenterprise activities (i.e., tissue making) for women's groups in villages covered by MCHI											O	O
Microentreprise activities							X	X	X	X	X	X
Direct Assistance to the DPS Promotion of vaccination days (Polio 1 & 2) and vitamin A	X	X										
Participate in monitoring of health facilities			X						X			
Participate in CTPS				X						X		
Participate in CTRS				X						X		
Reports Due Quarterly Reports			X			X			X			X

Activities Added to the Time line – October 1998-1999

Activities	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.
FARN CYCLE 1		X	X										
FARN CYCLE 2						X							
FARN CYCLE 3								X					
Preparations for FARN Workshop								X	X	X	X	X	X
National FARN Workshop													X
NGO Coordination Workshop (for NGOs working in Dabola and Dinguiraye)					X			X					X

ANNEX H

REFERENCES

REFERENCES

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ANNEX I

EVALUATION TEAM MEMBERS

EVALUATION TEAM MEMBERS

Bonnie Kittle – Team Leader, Outside Consultant.

Gouley Cisse – MCHI Assistant Coordinator

Tadiba Kourouma – MCHI Assistant Capacity Building (newly hired)

Kadiatou Keita – Midwife from MOH (Conakry)

Abdoulaye Diallo – MCHI Assistant Supervisor

Etiene Wendeno – DPS Health Center Head